

# TRUE VISION OPTOMETRY

1410-6004 Country Hills Blvd NE  
Calgary AB, T3N 1T8  
Ph: (403) 226-5171  
Fax: (403) 226-5173

## Patient Registration Form

Name: \_\_\_\_\_ Today's Date (yyyy-mm-dd) \_\_\_\_\_

(Last) (First) (Middle)  
Date of Birth (yyyy-mm-dd): \_\_\_\_\_ Sex: M/ F Primary Language: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  Check to be entered to receive SMS Text only for  
appointments and product notification

AHC #: \_\_\_\_\_ Third Party Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_ Member ID: \_\_\_\_\_

Address: \_\_\_\_\_  
(Full Address: Street, City, Postal Code)

Email Address: \_\_\_\_\_  Check to be entered to receive emails  
only for appointments and product notification

How did you hear about us? \_\_\_\_\_

Preferred Appointment Confirmation Method:  Text Message  Email  Phone Call

Emergency Contacts Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Clinic name: \_\_\_\_\_

Reason of today's visit \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Please check off any visual symptoms or concerns you have?

- Blurry Vision  Contact lenses  Dry eyes  Macular Degeneration  Glaucoma  Diabetes  High blood pressure  
 itchy eyes  Headache  Plaquenil Use  Flashes  Floaters  Eye Strain/Tiredness  Double vision  Cataracts

List any other problems: \_\_\_\_\_

Any eye surgery or trauma ?  Y /  N Type \_\_\_\_\_  Right  Left Date \_\_\_\_\_

Do you wear glasses?  Y /  N If yes,  Reading  Driving Do you wear contacts?  Y /  N C/L Brand \_\_\_\_\_

Medical History:  High Blood Pressure  Diabetic  High Cholesterol  Thyroid  Autoimmune  
Other \_\_\_\_\_

Please list All Medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_

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## CONTACT LENS CARE

**AGREEMENT:** Contact lenses are a medical device that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of the Alberta College of Optometry require an annual examination for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, poor surface compatibility in addition to any vision changes. The estimated fee for these services range between \$50.00 and \$75.00. These fees will cover any contact lens related follow ups for a 30 day period. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional \$40.00 visit beyond the global time period within Contact lens expiration. By signing, you acknowledge that you understand the policies regarding the fitting of contact lenses and agree to the associated fees. You understand that these fees are an estimate and are subject to changes based on the doctors final assessment. You also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage and if an infection is present you will need to be treated under your medical insurance prior to being fit with contact lenses.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Policy:** I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including Alberta Health Care, private insurance and any other health plans to True Vision Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed True Vision Optometry within 60 days, I may be billed for any services or products that you have received. I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I Certify That I understand that there are no refunds or exchanges and that sales are final unless covered under manufacturer warranty or office warranty programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_