OKOTOKS EYECARE

Name: _____

Gender: ☐ **M** ☐ **F**

AHC#: _____

Home Phone: _____

Address: _____

Email Address: _____

Date:

Birth Date: _____

Cell Phone: _____

Occupation: _____

Family Doctor: _____

How did you hear about us?
Name of Friend or Relative that referred you
(so we can thank them)

_____

_____ Website
_____ Newspaper Advertisement
_____ Welcome Wagon
_____ Location
_____ Other

Insurance Provider: _____

Policy #: _____

Group #: _____

Policy holder name and birthdate: _____

_____

We can direct bill many providers, but it is your responsibility to know the terms of your vision care.

Check if you are interested in any of the following?

☐ Prescription sunglasses
☐ Sports/hobby eyewear
☐ Computer glasses
☐ Bedtime reading

Do you currently have difficulty with any of the following?

☐ Glare/Reflection
☐ Red/itchy eyes
☐ Dry/watery eyes
☐ Floaters or spots in vision
☐ Side vision loss
☐ Frequent headaches
☐ Double vision
☐ Discomfort in brightness

Do your wear contact lenses?

☐ Yes, full time
☐ Yes, part time
☐ No, but I am interested
☐ No, I am not interested

Are you a Smoker?

☐ No
☐ Yes

Do you or your immediate family have a history of:

Self	Family (Please provide relation to you)	
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Lazy/Wandering Eye
☐	☐	Retinal Detachment
☐	☐	Blindness
☐	☐	Other Eye Disease
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Heart Disease/Stroke
☐	☐	Thyroid Disease
☐	☐	Other Disease

Medications _____

_____

Allergies _____

_____

Privacy Information

Information contained in your file will NOT be shared with outside parties without your consent. By signing below you consent to sharing relevant information with professionals who are directly involved in your care ONLY if necessary. Every efffort will be made to protect your privacy.

***Complete Privacy Policy available upon request**

Please circle how you would like to recieve notice for:

Appointment Reminders
☐ Phone ☐ Text ☐ Email

Yearly Appointment Recalls
☐ Phone ☐ Text ☐ Email

Glasses/Contact Lens Order Updates
☐ Phone ☐ Text ☐ Email

Contact Lens Due Updates
☐ Phone ☐ Text ☐ Email

Signature _____

*Due to the new privacy information act, insurance companies will no longer provide us with your benefits schedule. If you have any questions regarding your insurance benefits, please contact your provider for details.