15 Rosswell Drive, Units 3 & 4
Courtice, ON
L1E 0E2

AVIS OPTOMETRIC CENTRE

Title: _____ Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred Method of Contact: _____

Birth Date (M/D/Y): _____ Health Card: _____

How Did You Hear About Us?: _____

Vision Benefits/Insurance Provider: _____

Policy Number: _____ Group/Member Number: _____

OCULAR HISTORY

Do You Currently Wear Glasses?: ☐ Y / ☐ N Use Low Vision Aids?: ☐ Y / ☐ N

Last Eye Exam: _____ By Whom?: _____

Patient and Family Ocular History:

Please indicate if you or anyone in your immediate family (mother, father, siblings, children, and grandparents) have a history of any of the following, and please indicate the relationship to you, the patient.

	Self	Family	Relationship
ARMD (Macular Degeneration			
Cataracts			
Glaucoma			
Keratoconus			
Lazy Eye/Amblyopia			
Retinal Detachment			

Please Indicate If You Have Any History Of The Following:

☐ Eye Surgery ☐ Eye Trauma ☐ Eye Infections

Please Indicate If You Ever Had or Currently Have Any Of The Following:

☐ Floaters ☐ Flashes of Light ☐ Double Vision ☐ Patching ☐ Visual Training

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Do You Wear Contact Lenses? ☐ Y / ☐ N How Often Do You Wear Your Lenses/Hours Per Day?: _____

How Often Are Lenses Disposed Of?: _____

Sleep In Your Lenses?: ☐ Y / ☐ N If Yes, Number Of Nights Before Removal?: _____

Brand of Lenses: _____ Solution: _____

MEDICAL HISTORY

Family Doctor/Location: _____

Medications: _____

Medication Allergies: _____

Environmental Allergies: _____

Patient and Family History: _____

Please indicate if you or anyone in your immediate family (mother, father, siblings, children, and grandparents) have a history of any of the following, and please indicate the relationship to you, the patient.

	Self	Family	Relationship
Asthma/Respiratory			
Autoimmune Disease (e.g. Rheumatoid Arthritis)			
Blood/Lymph			
Cancer			
Cardiovascular Disease			
Depression			
Diabetes			
Gastrointestinal Disease			
Hypertension			
Kidney Disease			
Multiple Sclerosis			
Neuromuscular Disease			
Skin			
Stroke (CVA)			
Thyroid			

Other: Please Explain

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Headaches: ☐ Y / ☐ N

Women: Pregnant/Nursing?: ☐ Y / ☐ N

SOCIAL HISTORY

Occupation: _____ Computer Use/Hours Per Day: _____

Hobbies/Sports You Participate In: _____

Do You Smoke Cigarettes? : ☐ Y / ☐ N

Are You An Ex-Smoker? : ☐ Y / ☐ N

If Yes, For How Long?: _____

What Year Did You Quit?: _____

PATIENT INFORMATION CONSENT FORM

By signing below, you have agreed to give your informed consent to the collection, use and/or disclosure of your personal information for the following:

- To provide quality eye care in a safe and efficient manner
- To enable us to contact you and to maintain communication with you
- To allow us to contact you to book and confirm appointments
- To allow follow-up treatment, care, and billing
- To communicate with other health care providers when necessary
- To comply with legal and regulatory requirements

I, _____, give my informed consent to Avis Optometric Centre to collect, use and/or disclose my personal information for the purposes listed above.

Signature: _____ Date: _____
