First Optometry New Patient Form

1. Your information

Name:

Address:

Date of Birth (Month/Day/Year):

Email address:

Preferred Daytime Phone Number:

Cell Phone Number (skip if same as Daytime Number):

Preferred Evening Phone Number (skip if same as Daytime Number):

Preferred Method of Contact: Tell us the best way to reach you

OHIP/Health Card Number (Numbers plus 2 Letters)

Health Card Expiry Date

Family Doctor:

Current Medications:

Allergies:

Do you have coverage through any of the following programs?

☐ Private Insurance ☐ Ontario Works ☐ ODSP ☐ First Nations and Inuit Health ☐ None of the above

2. Please check off any conditions that apply to you or your family members:

	Self	Family
Glaucoma		
Cataracts		
Diabetes		
Retinal Detachment		
Crossed/Lazy Eyes		
Macular Degeneration		
High Blood Pressure		
Heart Problems		
Stroke		
Thyroid condition:		
Previous ocular surgery		
Other		

If Other, please note here:

____

3. What are your current concerns regarding your eyes and vision?

- ☐ Poor vision ____________
- ☐ Ocular discomfort ____________
- ☐ Red eyes ____________
- ☐ Eyestrain ____________
- ☐ Double vision ____________
- ☐ Floaters/Flashes ____________
- ☐ Update prescription ____________
- ☐ Dry eyes ____________
- ☐ Itchy eyes ____________
- ☐ Headaches ____________
- ☐ No concerns ____________

4. How long has it been since your last eye examination?

____

5. Glasses History (skip if you don't wear glasses)

What types of glasses do you own?

☐ Single vision reading glasses (prescription) ☐ Single vision distance glasses ☐ Computer glasses
☐ Bifocals with a Line ☐ Progressives (no line bifocal/multifocal) ☐ Safety glasses
☐ Prescription sunglasses ☐ Non-prescription sunglasses ☐ Blue light blocking non-prescription glasses
☐ Sports goggles ☐ Cheaters

Are you in need of new glasses at this time?

☐ Yes ☐ No

6. **Contact Lens History (skip if you don't wear contact lenses)**

   What brand of contact lens do you wear?

   ____

   How often do you replace or dispose of your contact lenses?

   ☐ Daily ☐ Every 2 weeks ☐ Every month ☐ Other

   If you answered "Other" to the above, how often do you replace your lenses?

   ____

   What is your typical wearing schedule? (Hours per day and days per week)

   ____

   Please check off all that apply to you:

   ☐ I am having issues with my vision when wearing my contact lenses
   ☐ I am having issues with discomfort or occasional dryness with my contact lenses
   ☐ I am very happy with my current contact lenses ☐ I am interested in refractive laser surgery

   Are you in need of new contact lenses?

   ☐ Yes ☐ No

7. **What is your occupation? (This helps us determine what your visual demands are.)**

   ____

8. **What are your main hobbies or activities? (Again, this helps us determine your visual needs.)**

   ____

9. **How many hours per day do you spend on screens (computers, smartphones)?**

   ____

10. **How did you learn about our practice or whom may we thank for referring you?**

    ____
    ____
    ____
    ____

11. **Please feel free to include any information you would like us to know that was not covered in the above questionnaire. Thank you for your time in completing this form!**

    ____
    ____
    ____
    ____

12. **If you qualify for OHIP coverage of your examination, OHIP will only cover the basic elements of an eye examination. The doctors at First Optometry use advanced diagnostic testing not covered by OHIP to detect an manage eye disease earlier and more precisely, resulting in better health outcomes. All non-OHIP covered testing is optional. These diagnostic services include Retinal Imaging, Anterior Segment Photography, Ocular Coherence Tomography (OCT), and Pachymetry.**

OHIP covered examinations ONLY need fill out the following:

- ☐ I consent to having OCT and retinal imaging for a fee of $79
- ☐ I consent to having only retinal imaging for a fee of $49
- ☐ I prefer not to have testing that is not covered by OHIP

13. **Cancellation Policy Due to the time we have set aside in our schedule for your appointment, we require 24 hours notice should you be unable to attend. This ensures that we are able to fill the appointment time with someone in need. A cancellation fee of $50 will be charged for all missed appointments without 24 hours notice.**

Cancellation policy consent

☐ I will give 24 hours notice cancellation if unable to attend my appointment. I will pay a $50 cancellation fee if I miss my appointment without proper notice.

14. **The information I have given on this intake form is accurate and complete to the best of my ability. I understand that my information will remain confidential unless allowed or required by law. When applicable, I acknowledge that I am responsible for the full cost of my appointment, potentially including advanced diagnostic testing not covered by OHIP, payable at the same time services are rendered.**

PLEASE BRING YOUR CURRENT GLASSES AND SUNGLASSES TO YOUR EXAM

15. **Thank you, The First Optometry Team**