New Patient Registration

Patient Profile

Name: _____

Gender: M F Date of Birth (MM/DD/YYYY): _____/_____/_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Please circle your preferred method of contact

☎Home: _____ ☎ Cell: _____

Email: _____

Health Card #: _____Version Code:_____Exp:_____

Employer: _____Occupation: _____

How did you hear about our clinic?

Google Search Flyer Walk-In Drive-by Advertisement

Referral? _____ Other_____

Primary Insurance

Insurance Company Name: _____

Plan Member Name: _____Date of Birth(MM/DD/YYYY): _____

Relationship to Member: Self ☐ Child ☐ Spouse ☐ Other: _____

Group/Policy #: _____Member ID #: _____

Do you authorize Envision Eye Care to submit necessary claims on your behalf (when applicable)?

Please check one: Yes ☐ No ☐

Form continued on back (please flip over)

Medical History

Family Physician

Dr._____ ☎: _____

Address: _____

Date of last Physical Examination: _____

Known Medical Conditions: (Diabetes, High Blood Pressure, Arthritis, Weight, etc.)

_____

Allergies: _____

Medications:_____

Ocular History

Date of last Eye Exam: _____

Are you aware of any eye conditions? (Glaucoma, Cataract, Eye turn, Retinal Detachment, other)

_____

Family eye conditions: _____

Please indicate any current conditions below:

- Blurred vision
- Headaches
- Glare/light sensitivity
- Foreign Body
- Watery Eyes
- Eye soreness/ Pain
- Redness
- Floaters or Spots
- Double vision
- Haloes
- Tired eyes
- Eye turn
- Dryness
- Burning
- Sandy/ Gritty Feeling

How many hours do you spend on the computer daily? _____

Glasses & Contact Lens History

How old are your current glasses? _____

Are you having problems with them? _____

What brand contact lens do you wear? _____

How old are your contact lens?_____

What solution do you use for contact lens? _____

How often do you wear your contact lens? _____

Are you having problems with them? _____

Are you considering refractive laser surgery? _____

Patient Signature: _____ **Date:** _____