Patient Information Form

Patient Information

Name:

Address 1:

Address 2:

City:

Province:

Postal Code:

Phone:

Email:

Personal Information

Gender:

Date of Birth:

Care Card #:

Occupation:

How did you hear of our office?

Glasses Information

Please tick any of the following that you wear

- ☐ Single Vision
- ☐ Bifocals
- ☐ Safety Glasses
- ☐ Backup Glasses
- ☐ Progressive
- ☐ Trifocals
- ☐ Sports Glasses
- ☐ Sunglasses

Contact Lens History (if applicable)

What brand of contact lenses do you wear?

Please complete the following
Right Eye:
Power
BC
Dia

Left Eye:
Power
BC
Dia

How often do you replace or dispose your contact lenses?

What brand of solution do you use?

How many hrs a day do you wear your contacts?

Patient Information Form

Medical History

When approximately was your last eye exam?

Who is your family doctor?

Please list any prescription medications you are taking:

Do you have any drug allergies?

Please list any eye conditions you have ever had (Glaucoma, Cataracts, Macular Degeneration, Retinal detachment)

Please list any eye conditions that run in your family (Glaucoma, Macular Degeneration, Retinal detachments)

Insurance Coverage

Do you have coverage for eye exams or glasses?

If Yes, please tick which apply:

- ☐ Veterans Affairs
- ☐ First Nations
- ☐ Human Resources
- ☐ OVP
- ☐ Greenshield
- ☐ Other

Please bring this form with you to your next appointment.

250-494-9266

www.summerlandoptometry.com