Sheridan Optometric Centre

We welcome you to our practice and ask that you kindly complete or correct the information on this sheet:

Name:
Address:

Preferred Daytime Phone number:
Email address:
Date of Birth:
OHIP #

General Health & Ocular History

Current Medications -

Allergies –

Family Doctor & contact information -

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

Self	Family	
☐	☐	-Glaucoma
☐	☐	-Cataracts
☐	☐	-Diabetes
☐	☐	-Retinal Detachement
☐	☐	-Crossed/Lazy Eyes
☐	☐	-Macular Degeneration
☐	☐	-High Blood Pressure
☐	☐	-Heart problems
☐	☐	-Stroke
☐	☐	-Thyroid Condition
☐	☐	-Other:

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

What Glasses do you currently own? (circle)

Single vision, Bifocals, Progressives, Trifocals, Safety glasses, Sports Glasses, Other

How many hours a day do you use a computer?

How many inches (approx) do you sit from your computer monitor?

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 your contact lenses?
What brand of solution do you soak your lenses in?

What is your typical wearing schedule?	Hours/day: Days/week:
Please check off all that apply to you	□ I am having problems with the vision out of my contact lenses □ I am having problems with the comfort of my contact lenses □ I am interested in refractive laser surgery

Occupation:
Hobbies:

Primary Insurance

Insurance Company Name
Insured's Name
Identification number
Group Number
Insured's Date of birth
Patient's relation to Insured

Secondary Insurance (if applies)

Cancellation Policy

A 24 hour notice is required for all appointment cancellations. A cancellation fee of $25 will be charged for all missed appointments without 24 hour notice.

The information that 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, payable at the same time as services are rendered.

Signature: _____ Date: _____

Patient Privacy Protection

At Sheridan Optometric Centre, we responsibly uphold your right to privacy and respectfully request your consent to continue to stay in contact with you to remind you when it is time to review my eye and vision care needs and through our periodic email newsletters and promotions from Sheridan Optometric Centre.

In order to provide proper eye care and services, Sheridan Optometric centre will collect some personal information including your contact numbers, date of birth, address, OHIP number, medical conditions and medications. This information may be shared in the event that you are referrred to another health care provider.

If you would like to provide consent to continue receiving reminder notices for your eye examinations and periodic informative email newsletters, please Sign below:

Signature: _____ Date: _____