NEW PATIENT FORM

dr. david oliphant Optometrist

Patient Information

Today's Date * mm/dd/yyyy

Date Of Birth * mm/dd/yyyy

Health Card # (5555-555-555-XX) *

Sex * ○ Male ○ Female ◉ Other

Legal Name *

First | Middle | Last

Address *

Address Line 1

Address Line 2

City | State / Province / Region | ZIP / Postal Code

Cell Phone * | Home Phone | Work Phone

Email *

Occupation * | Hobbies:

Family Doctor * | Approximate Date of Last Eye Exam *

Primary Insurance Information

Do you Have Third Party Insurance (Manulife, Sunlife, etc)
◉ Yes ○ No

Primary Insurance Carrier's Name (Manulife, Sunlife, Canada Life, etc)

Policy Holder Name *
First | Last

Relationship to patient *
◉ Self ○ Parent ○ Significant Other ○ Sibling ○ Child ○ Friend
Other

Group # *

Policy / Member ID # required *

How did you hear about us *
○ Google ○ Driving By ◉ Friend/Family
Other

I would like to receive by yearly appointment reminders by: *
○ Email ◉ Phone Call

Do you have a second insurance carrier?
◉ Yes ○ No

Medical History

Are you currently taking any medications? *
◉ Yes ○ No

Do YOU suffer from any of the following? *
- ☐ Diabetes
- ☐ Allergies
- ☐ High Cholesterol
- ☐ Regular Headaches
- ☐ Difficult judging Depth
- ☐ Eye Injury
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Difficulty with Colour
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Multiple Sclerosis
- ☐ Double Vision
- ☐ Eye Surgery
- ☐ Itchy or Dry Eyes
- ☐ Glaucoma
- ☐ Eye Turn
- ☐ None of the above

Does a FAMILY MEMBER suffer from any of the following? *
- ☐ Diabetes
- ☐ Macular Degeneration
- ☐ Difficulty With Colour
- ☐ Glaucoma
- ☐ Eye Turn
- ☐ None of the Above

Glasses

Do you have difficulty: *
- ☐ Seeing up close
- ☐ Seeing the computer
- ☐ Seeing far away
- ☐ N/A

My Current Glasses Are *
- ○ 0-2 Years old
- ○ 2-4 Years old
- ○ >5 years old
- ○ N/A

Do you have, or have you ever worn: *
- ☐ Glasses for Distance
- ☐ Glasses for Reading
- ☐ Computer Glasses
- ☐ Lined Bifocals
- ☐ Progressives (No Line Bifocals)
- ☐ Prescription Sunglasses
- ☐ Transitions Glasses (Change colour outside)
- ☐ Over the counter Readers
- ☐ Never Owned Glasses

What do you Value Most in Glasses (Pick 3)
- ☐ Technology
- ☐ Ease of Use
- ☐ UV Protection
- ☐ Durability
- ☐ Appearance
- ☐ Cost

Where Did you Get your Last Pair of Glasses From? *

Contact Lenses

Do you / have you ever worn contact lenses? *
○ Yes ○ No ○ Used to but not anymore

Do you ever sleep in your contacts?
○ Yes ○ No

How often do you wear your contacts?
○ 5-7 Days/Week ○ 1-4 Days/Week ○ < 1 Day/Week

If No, are you interested in Contact Lenses?
◉ Yes ○ No

Are you happy with your contacts?
○ Yes ○ No

How Often Do you Dispose of Your Contacts?
○ Daily ○ Bi-Weekly ○ Monthly ○ >Monthly

What Brand of Contacts do you wear?

What do you Value Most in Glasses (Pick 3)
- ☐ Comfort
- ☐ UV Protection
- ☐ Breathability
- ☐ Convenience
- ☐ Health
- ☐ Cost

Eye Discomfort

1a. During a typical day in the past month, HOW OFTEN did your eyes feel discomfort?
○ Never (0) ○ Rarely (1) ○ Sometimes (2) ○ Frequently (3) ○ Constantly (4)

1b. When your eyes felt discomfort, HOW INTENSE was the feeling of discomfort at the end of the day?
○ N/A (0) ○ Not at all intense (1) ○ Sometimes (2) ○ Frequently (3) ○ Constantly (4) ○ Very Intense

Eye Dryness

2a. During a typical day in the past month, HOW OFTEN did your eyes feel dry?
○ Never (0) ○ Rarely (1) ○ Sometimes (2) ○ Frequently (3) ○ Constantly (4)

2b. When your eyes felt dry, HOW INTENSE was this feeling of dryness at the end of the day, within 2hrs of bed?
○ N/A (0) ○ Not at all intense (1) ○ Sometimes (2) ○ Frequently (3) ○ Constantly (4) ○ Very Intense

Watery Eyes

3. During a typical day in the past month, HOW OFTEN did your eyes look or feel excessively watery?
○ Never (0) ○ Rarely (1) ○ Sometimes (2) ○ Frequently (3) ○ Constantly (4)

I give consent to:
- The release of relevant findings to other health care providers
- The use of my email and phone number for methods of communication to and from the office
- This office for direct billing to my insurance, on my behalf, when available.

Authorization *

Print Name