



Adult New Patient Intake Form (16 and over)

Date		First name		Last name	
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Preferred First name		Gender		Birth Date	
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Full Address					
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Preferred Phone #		landline	<input type="checkbox"/>	cell	<input type="checkbox"/>	If cell, may we text? Y	<input type="checkbox"/>
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Alternate Phone #

Email		*If provided, used for appointment communications (Text/Phone alt methods)			
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Family doctor		Last optometrist		Occupation	
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Is 'Corrective Eyewear' a restriction on your driver licence? Y N Not Sure N/A

FOUND US. HOW?	FRIEND/FAMILY <input type="checkbox"/>	SIGN <input type="checkbox"/>	FACEBOOK/INSTAGRAM <input type="checkbox"/>	GOOGLE/WEBSITE <input type="checkbox"/>	SAW DR C BEFORE <input type="checkbox"/>	DR REFERRAL <input type="checkbox"/>
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What is the main reason for requesting an exam?					
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Do you wear glasses?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Do you wear contacts?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Interested	<input type="checkbox"/>
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*For contact lens wearers only: Brand/Rx for each eye

Do you frequently use eye drops?	Y <input type="checkbox"/>	N <input type="checkbox"/>	If yes, what type/for what?			
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Recent eye injuries/infections/inflammations?	Y <input type="checkbox"/>	N <input type="checkbox"/>	If yes, details:			
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Eye surgical history?	Y <input type="checkbox"/>	N <input type="checkbox"/>	If yes, details:			
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Headaches?	<input type="checkbox"/>	Sore Eyes?	<input type="checkbox"/>	Red Itchy Eyes?	<input type="checkbox"/>	Eyes feel dry?	<input type="checkbox"/>	Watery Eyes?	<input type="checkbox"/>
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Reading issue?	<input type="checkbox"/>	Issue seeing computer?	<input type="checkbox"/>	Far vision issue?	<input type="checkbox"/>	Worse night vision?	<input type="checkbox"/>
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Any personal eye/vision related history (eye disease/anomaly)?

Medical History		Medications	
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*Do you smoke? Y N Quit (FYI smoking is a major risk factor for eye disease)

Eye Disease in Family?	<input type="checkbox"/>	Allergies?	<input type="checkbox"/>
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YOUR SPECTACLE PRESCRIPTION IS YOURS. YOU OWN IT. YOU CAN REQUEST IT ANYTIME, AND WE WILL ALWAYS PROVIDE YOU WITH A COPY. IN AN EFFORT TO REDUCE WASTE AND PRESERVE TREES, WE HAVE ELECTED TO ONLY PRINT SPECTACLE PRESCRIPTIONS WHEN SPECIFICALLY ASKED BY YOU, THE PATIENT, TO DO SO. YOUR UP-TO-DATE SPECTACLE PRESCRIPTION IS ALWAYS ON FILE, ONCE AN EYE EXAM HAS BEEN COMPLETED, AND IS VALID FOR 1 YEAR FROM THE DATE OF THE EXAM. TO PROVIDE OPTOMETRIC CARE, WE WILL COLLECT AND MAINTAIN RELEVANT PERSONAL AND HEALTH INFORMATION APPROPRIATELY. IF NECESSARY, THIS INFORMATION MAY BE SHARED WITH OTHER RELEVANT HEALTHCARE PROVIDERS. WE WILL ALWAYS SEEK TO OBTAIN YOUR DIRECT CONSENT FOR ANY EXTRAORDINARY PROCESSES/PROCEDURES THAT MAY BE DEEMED NECESSARY. YOU SIGNATURE IS INDICATIVE THAT YOU HAVE COMPLETED THIS FORM TO THE BEST OF YOUR ABILITIES AND THAT YOU UNDERSTAND AND AGREE TO THE CONSENT THEREIN.

Patient/Parent/Guardian Signature (FULL NAME, TYPED, IS ACCEPTABLE)	
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