Merritt Eye Care
—FAMILY OPTOMETRY—
Vision • Health • Style

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NEW PATIENT INFORMATION FORM – *Welcome!*

Date: MM/DD/YYYY

Patient's Legal Name: FIRST, MIDDLE, LAST Preferred Name: _____

Title (circle one): **Mr. Mrs. Miss Ms. None Other** _____

Address: _____ Home #: _____

City: _____ Work #: _____

Province: _____ Cell #: _____

Postal Code: _____ Email: _____

By adding your email address or cell phone # you agree to receive electronic messages (recalls, confirmations) from the office of Merrit Eye Care. You may opt out at any time and we do not sell to third parties.

Patient's Date of Birth: MM/DD/YYYY Health Card#: _____ Version Code: _____

How did you hear about us? ❑ Family/Friend ❑ GP ❑ Social Media ❑ School ❑ Welcome Wagon ❑ Other_____

Occupation (or Grade): _____ Name of Employer (or school): _____

Name of spouse/parent/next of kin: _____

Who is your family physician? _____ City: _____

Previous Eye Doctor: _____ City: _____ Last Eye Exam: MM/DD/YYYY

Please ***circle*** if you have ever had any of the following:

Cataracts / Glaucoma / Lazy Eye / Diabetes / Allergies / Macular Degeneration /
Eye Infections / High Blood Pressure / Hepatitis / HIV Do you Smoke? **Yes / No**

List any other medical problems/concerns: _____

List all medications you take: _____

Have you ever had an eye injury or eye surgery? **Yes / No** (Describe): _____

_____

List any blood line relatives that have/had glaucoma, macular degeneration or other loss of sight? Cause?

_____

Are you allergic to any medications? **Yes / No** (List): _____

Do you presently wear contact lenses? **Yes / No** If no, have you ever worn contacts? **Yes / No**

Do you wear glasses? **Yes / No** How old are the glasses? _____ When do you wear them? _____

Do you drive? **Yes / No** Are glasses required to drive? **Yes / No**

Recall - Would you like us to contact you when it's time for your next examination? **Yes / No**

(This may come through automated phone call, email or SMS with our automated server)

Do you currently have vision care insurance? **Yes / No** Name of provider: _____

Please give benefit plan card to the receptionist.

Please note: *Insurance may cover all, none or only part of your fees. We will be happy to assist you with your claims.* ***If your insurance carrier does not pay us directly, you will be required to pay our office at the time of service and submit your receipt directly to your insurance company for reimbursement (this is often different than dentistry and pharmacy).*** *If your insurance does not pay as expected, you are responsible for the unpaid charges. Please be sure to check your eligibility with your provider.*

Signature _____ *(turn over for reverse side)*

RE: YOUR HEALTH INFORMATION AND YOUR PRIVACY

Our privacy policy is available on our website www.merritteyecare.ca for your perusal. If you have any further questions, please feel free to discuss them with us. Your privacy is important to us and is not shared with a third party except for other health care practitioners as indicated, where required by law or practice management or at your request.

Legislation modifying the Privacy Act was implemented on January 1, 2004 concerning the sharing of information. This involves your personal and health information and how it is shared with other people. It is now necessary to give written authorization for sharing of information with your spouse, children, and parents (if you're over 16 years of age), friend(s), etc.

Completion of the following will allow us to discuss these matters with another person if you choose. This will be in effect until written notification is received from you stating otherwise. Personal information should not be sent via email without encryption therefore we prefer contact by fax or phone.

This letter will serve to grant my permission for Merritt Eye Care to discuss my personal information regarding appointment results, glasses/contact lenses and/or referral appointments with the person(s) listed below. Please note that you may also decline to list anyone.

☐ *I do not want to list anyone at this time.*

I hereby give my permission to share my information with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Signed,

_____ _____ _____

Signature Print Name Date

For more information about eye care or our office, visit us on our website at ***www.merritteyecare.ca****.*