Patient Information

Please make all applicable corrections below.

NAME:
DATE OF BIRTH:
ADDRESS:
HOME PHONE:
WORK PHONE:
CELL PHONE:
E-MAIL ADDRESS:

Service Card/BC Care Card:
Insurance Company:
Group/Policy Number:
Member ID Number:

Check off all that apply:

Self	Family	
□	□	Macular degeneration
□	□	Glaucoma
□	□	Cataracts
□	□	Blindness
□	□	Retinal degeneration
□	□	Crossed / Lazy eyes
□	□	Color blindness
□	□	High blood pressure
□	□	Diabetes
□	□	Heart problems
□	□	Cholesterol
□	□	Stroke
□	□	Cancer
□	□	Arthritis
□	□	Thyroid Condition
□	□	HIV/ Hepatitis
□	□	Asthma/ Allergies
□	□	Neuromuscular
□	□	Autoimmune: ______________
□	□	Other: ____________________
□	□	Pregnant or Nursing

What brought you in:

□ Blurry distance vision
□ Blurry near vision
□ Poor night vision
□ Eye strain
□ Glare / Reflections
□ Sandy / Dry eyes
□ Watering
□ Discharge
□ Pain in the eye
□ Burning eyes
□ Red eyes
□ Itchy eyes
□ Discomfort in sunlight
□ Floaters or spots in vision
□ Flashes of light
□ Double vision
□ Headaches
□ Eye injury: ________________
□ History of eye patch wear
□ History of eye surgery
□ Dental Abscess
□ Other:

Are you interested in:

□ New spectacles
□ Contact lenses
□ Colored contact lens
□ Light weight glasses
□ Anti-reflective lens
□ Sunglasses
□ Clip-ons
□ Safety glasses
□ Lasik
□ Dry eye therapy

How you were referred to us:

□ Family doctor
□ Insurance Company
□ Google / Web Search
□ Another patient: ___________
□ Other: ___________________

Social history:

□ Tobacco use
□ Alcohol use
□ Drug use

Last eye exam: ___________________________________
Medications: ___________________________________
Occupation: ___________________________________
Allergies: ___________________________________
Family Doctor: ___________________________________

Privacy and Personal Health Information

Vision Plus Optometrists Corporation is required by law to maintain the privacy of your personal health information. We may use or disclose health information you provide for the following purposes: treatment and related services (e.g. providing appointment reminders, other treatment options, benefits including promotions, etc.), billing and receiving payment from you, insurance companies or other third parties, sharing with other medical practitioners, family members or authorized agents involved with your medical care or as required by court order or law. It will be secured and kept private by members of the clinic staff in accordance to Canadian Law.

Consent to Disclose to Insurance Providers

By signing below, if applicable, you authorize Vision Plus Optometrists Corporation to share your personal health information with your insurance company or third-party provider for the purpose of direct billing and payment for services and products.

Signature of patient / authorized representative: ________________________________ **Date:** ____________________