YORKVILLE EYECARE

PATIENT REGISTRATION

Circle Title: Mr. Mrs. Ms. Miss

First Name: ______________________________

Last Name: ______________________________

Guardian Name: ______________________________

Date Of Birth: M: _______ **D:** _______ **Y:** ______

Address: ______________________________

______________________________ **APT:** _________

City: ___________________ **Postal:** ___________

Health Card #: ______________________________

Health Card Version Code (letters): ___________

Please Check Only If: ☐ ODSP ☐ Ontario Works

Home Phone #: ______________________________

Work Phone #: ___________________ **EXT:** _____

Cell Phone #: ______________________________

Email Address: ______________________________

Occupation: ______________________________

Hobbies: ______________________________

How did you hear about us? ☐Family/Friend ☐Family Doctor ☐Internet ☐Mall ☐Other ___________

Family Doctor: ______________________________

OCULAR HISTORY

Self	Family	
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Retinal Disease
☐	☐	Lazy Eye
☐	☐	Eye Injury
☐	☐	Eye Surgery

Other:______________________________

Last Eye Exam Date: M: ____ **D:** ____ **Y:** ________

By Whom? ______________________________

Reason for today's visit?

☐ Doctor's Request ☐ Emergency ☐ Routine Exam

☐ Contact Lenses ☐ Laser Eye Surgery

☐ Other______________________________

MEDICAL HISTORY

Self	Family	
☐	☐	High Blood Pressure
☐	☐	Diabetes
☐	☐	Heart Disease
☐	☐	Cholesterol
☐	☐	Thyroid
☐	☐	Respiratory

Other:______________________________

Last Physical Exam Date: M: ____ **D:** ____ **Y:**____

By Whom? ______________________________

Drug allergies? ☐ No ☐ Yes

Please List:______________________________

Medications (Including eye drops)? ☐ No ☐ Yes

Please List:______________________________

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Communication Preferences: Our clinic offers the opportunity to receive **next appointment reminders** by email, telephone, or postcard. By selecting your preference(s) below, you are consenting to receive appointment reminders, or occasional office information using the method specified below. Your consent may be withdrawn at any time by contacting our office directly. (**Please select all that apply**)

☐ E-mail ☐ Phone ☐ Postcard ☐ I do not wish to receive reminders

Signature: Date: