PLACE PATIENT LABEL HERE

PATIENT INTAKE INFORMATION FORM

Welcome to the SIMCOE OPTOMETRIC CLINIC! Thank you for completing this form as thoroughly as possible to allow us to most accurately meet your vision care needs.

Preferred first name: ________________________________

Reason for today's appointment: (*Please check all that apply.*)

Routine eye exam / eye health assessment
New glasses
MTO Driver's Testing Form
Vision Changes
Interested in contact lenses
Other __________________________

When was your last eye exam? ____

Previous eye doctor's name & city? ____

Do you wear glasses? ☐Yes ☐No If yes, how old are your current glasses?______________

Do you wear contact lenses? ☐Yes ☐No

Are you currently experiencing any specific issues with your eyes?

____

Have you been diagnosed with any of the following eye conditions? (*Please check all that apply.*)

Blepharitis
Cataracts
Dry Eye
Strabismus (Eye Turn)
Glaucoma
Amblyopia (Lazy Eye)
Macular Degeneration
Retinal Detachment
Retinal Vascular Disease
Other

Do you have any family members (grandparents, parents, siblings) with any of the above ocular conditions? If yes, please list ____

Have you ever had any eye injury or surgery on your head or eyes?
If yes, please list: ____

Do you have allergies to any medications or foods? If, so, please list __________________________

Have you been diagnosed with any of the following medical conditions?

Cancer
High Blood Pressure
Rheumatoid Arthritis
Thyroid Disease
Diabetes
High Cholesterol
Seizures
Other ____________________
Heart Disease
Migraines
Stroke

(Form continued on the other side)

SIMCOE OPTOMETRIC – PATIENT INTAKE INFORMATION FORM – *PAGE 2*

How did you hear about Simcoe Optometric Clinic? ___________________________________

We are happy to notify you when you are due for your annual exam. How would you like us to contact you? By providing permission below, you consent to receiving electronic communications from us and may withdraw this permission at any time.

☐ Text – please ensure we have your current cell phone number ______________________________
☐ Email – please provide your email address below

______________________________ @ _______________________________

Adults with healthy eyes should be checked every two years, while children should have yearly exams even if they see perfectly to identify eye disease before vision is lost. People with eye disease or certain general health problems may need to be seen more frequently. Is there someone in your household or in your care that you would like to book an eye exam for? If yes, please let us know.

X Please sign completed form here:____

Date: ___________________________

VISION CARE COVERAGE
Do you have vision care coverage through any of the following?

☐ ODSP ☐ Ontario Works ☐ Indian Affairs

If yes, please provide your client number # _______________________________________

INSURANCE
We can direct bill to a number of insurance companies, if you would like us to try to direct bill on your behalf, please complete the section below.

☐ Yes, I give authorization to Simcoe Optometric Clinic to submit personal information – ***if they are able to*** – as necessary for claims adjudication and for my insurance company to exchange information with other parties as required to fully process my claim and confirm any applicable information.

Insurance Company Name: ____

Insurance Policy #: _________________________ Member ID #: ____________________________

Primary Plan Member: Last name: ____

First name: _____________________________ Date of Birth: _______________________________

Are you or your dependents entitled to benefits under any other plan, than the one noted above? If yes, please list details ____

X Please sign here for insurance purposes:____

Date: ___________________________