SPECS AND SPINES
OPTOMETRY & CHIROPRACTIC

CHILD/YOUTH - NEW PATIENT REGISTRATION FORM

To assist us in providing the best quality care, please fill out this form and submit at your appointment. All personal and health information is confidential.

CONTACT INFORMATION

Gender: M / F (please circle)	Surname		First name		
Street Address				Apt/Unit #	
City, Province				Postal Code	
Parent/Guardian Name				Same address?	
Phone Number	Home	Mobile		Work	
E-Mail					

PERSONAL INFORMATION

Date of Birth (Day/Month/Year)		Age	
OHIP/Health Card #		Version Code (Letters)	
Hobbies			
How did you hear about us?	Please circle: ◯ Website ◯ Family/Friend ◯ Walk-by ◯ Doctor _____ Other: (please describe):_____		

HEALTH HISTORY

Parents, does your child...

Squint (other than in very bright light)?	◯ Y	◯ N	Have one eye that drifts in/out?	◯ Y	◯ N
Tilt his/her head frequently?	◯ Y	◯ N	Rub his/her eyes?	◯ Y	◯ N
Have very watery eyes?	◯ Y	◯ N	Complain of headaches?	◯ Y	◯ N
Hold objects very close/sit close to the TV?	◯ Y	◯ N	Tell you that he/she has difficulty seeing?	◯ Y	◯ N

Birth History: Full Term ◯ Premature ◯ (# weeks ____) Birth weight: (lbs, oz) _____

Is your child currently taking any medications? If so, please list.

_____

Does your child have allergies to any medications? If so, please list.

_____

Are there any eye conditions that run in your child's family (ex: amblyopia, crossed eye, glaucoma, etc.)?

_____

Recommended Retinal Photography for Ages 8yrs+

We recommend retinal photography as an integral part of an eye exam. A retinal photo is a permanent record for your child's medical file which can be used during exams for years to come to monitor for any changes that may occur in your child's eye health. **Retinal screening photos ($35)** ☐ Yes ☐ No _____ (parent initials)

Privacy Policy

Our optometry clinic is committed to collecting, using and disclosing your personal information in a responsible manner. The privacy practices of our office are in accordance with all federal and provincial law and regulations.

I understand that my personal information will be kept confidential in accordance with The Registered Health Practitioners Act and Personal Information Protection and Electronic Documents Act (PIPEDA). I understand that for the purposes of communication between this office and the patient that I will periodically receive e-mails regarding appointments, orders and newsletters. To opt out of this email option, I will inform Dr. Ivy Koh and Specs & Spines Optometry in writing.

Patient or Parent Signature _____ Date (D/M/Y) _____