SPECS AND SPINES
OPTOMETRY & CHIROPRACTIC

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

Mr / Mrs./ Ms. / Dr (circle)	Surname		First name		
Street Address				Apt/Unit #	
City, Province				Postal Code	
Phone Number	Home	Mobile		Work	
E-Mail					

PERSONAL INFORMATION

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

MEDICAL HISTORY

Last medical examination(Mth/Yr): _____Family Physician: _____

Do you or any blood relative have any of the following medical conditions?

	SELF	RELATIVE	List relative
Diabetes	☐	☐	
Hypertension	☐	☐	
Thyroid Disease	☐	☐	
Heart Disease	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	(Type of Cancer): _____
Other:	☐	☐	

Smoking History: ☐ N/A ☐ Current ☐ Ex-smoker

Please list any other medical conditions you have been diagnosed with:

_____

Please list any current medications you are taking:_____

_____

Please list any allergies you may have (seasonal, medication): _____

OCULAR HISTORY

Reason for today's eye examination? : _____

Last eye examination: (Mth/Yr): _____Doctor : _____ Age of current spectacles:_____

▼TURN OVER▼

OCULAR HISTORY

Do you or any blood relative have any of the following eye conditions?

	SELF	RELATIVE	list relative
Glaucoma	☐	☐	
Cataract	☐	☐	
Retinal Disease	☐	☐	
Macular Degeneration	☐	☐	
Amblyopia (Lazy Eye)	☐	☐	
Strabismus (Cross Eye)	☐	☐	
Blindness/Low Vision	☐	☐	

Please list any eye injuries or surgeries: _____

Please list any eye medications or drops you are taking: _____

Do you have interest in refractive surgery candidacy (lasik?) ☐ Yes ☐ No

CONTACT LENS HISTORY

If you are a current contact lens wearer, please answer the following questions:

Brand: _____ Type of Lens: ☐ Daily ☐ Biweekly ☐ Monthly ☐ Yearly ☐ Rigid

Contact Lens Solution: _____ Frequency of wear (# days per week): _____

Please check all that apply:

☐ I am interested in trying the newest contact lens designs

☐ I am interested in altering or enhancing my eye colour with contact lenses

☐ I am interested in multifocal contact lenses

RECOMMENDED RETINAL SCREENING

We recommend retinal photography as an integral part of your dilated eye exam. A retinal photo is a permanent record for your medical file, which enables us to make important comparisons if potential problems show themselves at a future examination. These photos capture the optic nerve, macula, and retinal arteries and veins and may detect conditions such as glaucoma, diabetes, high blood pressure, high cholesterol, and macular degeneration

Retinal screening photo: INCLUDED WITH PRIVATE PAY EXAMS, $35 FOR OHIP EXAMS

☐ Yes ☐ No ☐ Would like to discuss with Dr. Koh (Sign 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. To opt out of this email option, I will inform Specs & Spines Optometry in writing

Patient Signature _____ Date (Day/Month/Yr) _____