



Patient Information Form

In order to provide quick and helpful service we ask that you please fill out the following sheet pertaining to you and your medical history.

Name _____
Last Middle Initial First

Date of Birth (mm/dd/yyyy) ____/____/____ Gender M F

Alberta Health Care Number _ _ _ _ _ - _ _ _ _ _

Mailing Address _____

City _____ Province ____ Postal Code _ _ _ - _ _ _

Contact Information

Home : (____) - ____ - ____

Cell: (____) - ____ - ____

Work: (____) - ____ - ____

Email: _____

Would you like to be emailed about any promotions or deals that happen in our office.

Yes

No

Insurance Information or Government Assistance Coverage (please print off the appropriate form from the Direct Billing page if available)

Family Doctor _____

Have you had your blood pressure checked recently (within the last 6 months)?

Yes

No

If Yes was it...

High Average Low

Are you pregnant (if Female)?

Yes

No

History of Medical Conditions (please check all that apply)

Glaucoma

Diabetes

Cataracts

Arthritis

Age Related Macular Degeneration

Cancer

Eye Surgery (Please Specify What For Below)

High Blood Pressure

Lazy Eye

Other (Please List Below)

If you are Diabetic are your sugar levels under control?

Yes

No

Family History of Medical Conditions (please check all that apply)

Glaucoma

Diabetes

Cataracts

Arthritis

Age Related Macular Degeneration

Cancer

Eye Surgery (Please Specify What For Below)

High Blood Pressure

Lazy Eye

Other (Please List Below)

Medications

Allergies

Occupation (and any specific jobs you do)

Hobbies

Extra Info

Optional

Is this your first visit to our office?

Yes

No

Do You Wear...

Prescription

Non Prescription

Glasses

Glasses

Contacts

Contacts

Sunglasses

Sunglasses

Would you be interested in finding out about Contact Lenses?

Yes

No

Would you be interested in finding out about Prescription Sunglasses?

Yes

No

Do you find overhead lighting or glare from computer/television screens strain your eyes?

Yes

No

Would you be interested in having your Glasses/Contact Lens purchases mailed to your place of residence? (If Yes, please list address underneath if not the same as initially filled out on Sheet 1)

Yes

No