CENTRAL OPTOMETRY

101-330 Ridout St N
London, Ontario
N6A 0A7

Today's Date (dd/mm/yyyy): ____/____/____ Date of Birth (dd/mm/yyyy): ____/____/____

Insurance Info

PRIVATE INSURANCE: ☐ Green Shield ☐ Manulife ☐ Sun Life ☐ Great-West Life ☐ None ☐ Other:

Policy #:	Member ID:
Primary Policy Holder:	Policy Holder DOB (dd/mm/yy):

Demographic Info

Last Name:	First Name:	Sex: ☐M ☐F ☐O
Address:	City:	Postal Code:
Home Phone:	Cell Phone:	
Business Phone:	Email:	

PLEASE LIST A MINIMUM OF 2 METHODS OF COMMUNICATION

Occupation:	Hobbies:
Family Doctor:	Last Eye Exam:

How Did You Hear About Us: ☐ Google ☐ YP.CA ☐ Driving By ☐ Friends/Family: _____ ☐ Other

I Would Like to Receive my Yearly Appointment Reminders By: ☐ Email ☐ Phone ☐ Postcard

Medical History

Do You or Any Family Members Have a History Of The Following?

	Self	Family	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Thyroid Disease	☐	☐	
Allergies	☐	☐	
Multiple Sclerosis	☐	☐	
Regular Headaches	☐	☐	
Double Vision	☐	☐	
Difficulty Judging Depth	☐	☐	
Eye Surgery	☐	☐	
Eye Injury	☐	☐	
Itchy Eyes	☐	☐	
Dry Eyes	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	Who:
Macular Degeneration	☐	☐	Who:
Eye Turn	☐	☐	Who:
Difficulty With Colour	☐	☐	Who:
None of the Above	☐	☐	

Medications

Please List Medications you are Currently Taking

☐ I Am Not Currently Taking Any Medications

Please See Reverse For Additional Question

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Glasses

	Yes	No
Do You Have Difficulty Seeing Up Close?	☐	☐
Do You Have Difficulty Seeing The Computer?	☐	☐
Do You Have Difficulty Seeing Far Away?	☐	☐
Do You Have or Have You Ever Worn:		
Glasses For Distance	☐	☐
Glasses For Reading	☐	☐
Computer Glasses	☐	☐
Lined Bifocals	☐	☐
Progressives (No Line Bifocals)	☐	☐
Prescription Sunglasses	☐	☐
Over The Counter Readers	☐	☐

Where Did You Get Your Last Pair Of Glasses?

_____

What Do You Value Most In Glasses (Select Up To 3)

☐ Technology	☐ UV Protection	☐ Appearance
☐ Ease of Use	☐ Durability	☐ Cost

Contact Lenses

	Yes	No	Maybe
Do You / Have You Ever Worn Contacts?	☐	☐	
☒ If No, Are You Interested?	☐	☐	☐
Do You Ever Sleep In Your Contacts?	☐	☐	
Are You Happy With Your Contacts?	☐	☐	

Why Not: _____

How Often Do You Wear Your Contacts?

☐ 5-7x/week ☐ 1-3x/week ☐ <1x/week

How Often Do You Dispose of Your Contacts?

☐ Daily ☐ Bi-Weekly ☐ Monthly

What Contact Lens Cleaning Solution Do you Use:

☐ Clear Care ☐ Opti-Free ☐ Biotrue ☐ _____

What Brand Of Contact Lenses Do You Wear?

_____

What Do You Value Most In Contact Lenses (Select Up To 3)

☐ Comfort	☐ UV Protection	☐ Breathability
☐ Convenience	☐ Health	☐ Cost

Authorization

I Give Consent To:	Initials
• The Release of Relevant Findings to Other Health Care Providers	
• The Use of My Email For Methods of Communication To And From This Office	
• This Office For Direct Billing To My Insurance, On My Behalf, When Available	

Signature: _____