GEORGINA EYE DOCTORS

MEDICAL HISTORY AND NEEDS FORM

ONTARIO ASSOCIATION OF OPTOMETRISTS

Hello _____,

Due to COVID-19, our office procedures have been enhanced for your safety. To ensure a safe and efficient visit for you, we require that you complete and submit this Medical History and Needs Form in the next 48 hours to guarantee your appointment.

Please also note that as part of our new safety measures, we have implemented a contactless pay system for those not covered by OHIP. This will ensure your visit to our office is both convenient and safe.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

"We" and "our" mean the following optometric practice: GEORGINA EYE DOCTORS

READ CAREFULLY: By filling out this form, you consent to our collection of the information above.

We collect, use and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services; to arrange payment for services; and as required by law.

The collection of this information is authorized by the *Health Insurance Act, Optometry Act, Regulated Health Professions Act* and *Health Protection and Promotion Act*.

We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.

Thank you for your cooperation.

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1. Patient information

Please fill out the following personal information

First Name*:	**Last Name*:**	**Email Address*:**		
Date of Birth:	**Address:** Address 1	Address 2		
Home Phone*:	City	State/Province	Zip/Postal Code	Country
Cell Phone:	**Preferred Method of Contact*:** Tell us the best way to reach you.	Email ☐	Phone ☐	Cell ☐
Family Doctor: ☐ **Yes** ☐ **No**	**Family Doctor Phone Number:**	**Emergency Contact*:** First Name:	Last Name:	
Insurance Information*: Do you have insurance? ☐ **Yes** ☐ **No** ☐ **I am unaware of my insurance information.**		Emergency Contact Phone Number:	Emergency Contact Email:	
Plan Name:	Policy #:	Group #:	Do you have dependant coverage? ☐ **Yes** ☐ **No**	
Please note that not all insurance companies allow us to direct bill for your ocular visual assessment. In this case, the patient will pay for the assessment and a receipt will be issued, which you can be submit to the insurance company.				
Health Card Information*: Name on OHIP				
Health card number:		Expiry date:		

2. Personal medical history

Please list any medical conditions:

Have you been diagnosed with an eye disease?

Please list any previous eye surgeries:

Please list all medications you are currently taking:

Please list any Allergies:

Please list any eye diseases that run in your family:

3. COVID-19 health history

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? ☐ Yes ☐ No	Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? ☐ Yes ☐ No
Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19? ☐ Yes ☐ No	Have you travelled recently? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain below.

4. Purpose of your visit

Please describe your condition or purpose of your visit.

5. Corrective lens information

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Do you wear the following?

Please check all that apply.

- ☐ Prescription Glasses
- ☐ Prescription Sunglasses
- ☐ Non-Prescription Sunglasses
- ☐ Contact Lenses
- ☐ I don't wear any of these.

b) What do you use most of the time?

Please check all that apply.

- ☐ Prescription Glasses
- ☐ Prescription Sunglasses
- ☐ Non-Prescription Sunglasses
- ☐ Contact Lenses
- ☐ I don't wear any of these.

6. Visual Needs

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Employment Information Our eyes are also working. Please tell us what you do for work.	**b) Job Description** Please describe your job duties to us.

c) Which do you do regularly?

Check all that apply.

- ☐ Night Driving
- ☐ Work Outdoors
- ☐ Commute 20+ min. By Car
- ☐ Work w/ Small Objects
- ☐ Work Under Fluorescent Light
- ☐ Read For Long Periods
- ☐ Work on a Computer
- ☐ Travel on Airplanes
- ☐ Watch TV for 3+ hrs/Day
- ☐ Work at a Desk
- ☐ Frequently Alternate Between Indoors & Outdoors

d) Hobbies/Recreation

To help us better understand how to use your eyes, please list any recreational activities or hobbies that you enjoy.

PLEASE BRING YOUR CURRENT GLASSES & SUNGLASSES TO YOUR EXAM

How did you hear about us?

- ☐ Family/Friend
- ☐ Google
- ☐ Website Appointment
- ☐ Walk In
- ☐ Family Doctor
- ☐ Other:

Thank you,

The GEORGINA EYE DOCTORS Team