PRIMARY EYE CARE CENTRE

Dr.McMorris, Dr.John, Dr.Gatrell & Dr.Lins

Date______________________

Name____ Occupation____________________________

Date of Birth____________________________________ Hobbies______________________________

Phone (h)__________________ (c)__________________ (w)____________________

Email ____ Next of Kin____________________________

If your last eye examination was NOT done in this office, how long has it been? ______________________

What is the MAJOR reason for this visit?____

If patient is a student, are there any concerns with schoolwork?____________________________________

How did you hear about our office?____

Was your most recent pair of glasses purchased here? Yes_____ No______

When do you wear glasses (circle all that apply): All the time, Watching TV, Reading/Near work, Driving

Do you wear contact lenses? Yes_____ No______ If yes, full time______ part time______

If yes, are you satisfied with them? Yes _____ No _____

I am interested in:	Personal Ocular History	Immediate Family History	Personal Medical History
□ New glasses	□ Cataract	□ Cataract	□ Diabetes
□ Contact Lenses	□ Glaucoma	□ Glaucoma	□ High Blood Pressure
□ Laser Surgery	□ Macular Degeneration	□ Macular Degeneration	□ High Cholesterol
□ Sunglasses	□ "Crossed" Eye	□ "Crossed" Eye	□ Stroke
□ Transition Lenses	□ "Lazy" Eye	□ "Lazy" Eye	□ Heart Problems
□ Sports Eyewear	□ Blindness	□ Blindness	□ Cancer
□ Safety Eyewear	□ Retinal Detachment	□ Retinal Detachment	□ Multiple Sclerosis
	□ Eye Injury __________ ____________________	□ Diabetes	□ Thyroid
	□ Other_____________ ____________________	□ High Blood Pressure	□ Arthritis / Autoimmune
	□ Eye surgery? _______ ____________________		□ Respiratory
			□ Allergy / Sinus
			□ Other _____________ ____________________

Do you smoke? Yes_____ No ______ If you have quit, how many years ago did you quit?______

If female, are you pregnant? Yes_____ No______

Family Physician's name?____

Allergies (including allergies to medications)?____

Please notify reception and mark any of the following gov't assisted program that apply:	• Please notify reception if you have 3rd party insurance coverage and present forms that may need to be completed.
□ FHB (Family Health Benefits)	• We are able to direct bill for selected providers.
□ SIP (Sask Income Plan for Seniors)	• Payment is due at the time of service and an extra receipt will be issued.
□ Supplementary Health (Social Services)	
□ DVA (Dep't of Veterans Affairs)	
□ FNIH (First Nations Inuit Health)	

In accordance with HIPA (Health Information Protection Act) and PIPA (Personal Information Protection Act), I ____________________________ authorize the release of only pertinent information to other eye care and health professionals as required. HIPA and PIPA prohibits the release to any information to 3rd party vendors.