AJAX FAMILY EYE CARE

Optometrists: **Dr. Sameer Patel**
Dr. Nina Gupta

Today's Date: ____/____/_____
M D Y

Demographic Information: **Date of Birth:** ____/____/_____
M D Y

☐ Male
☐ Female _____ _____
Last Name **First Name**

Name of Parent/Guardian if under 18 yrs old: _____

Address_____ **City**_____

Postal Code_____ **Email Address:** _____

Home Ph. # _____ **Cell Ph. #** _____

Family Doctor Name and Ph #: _____

Health Card # _____ **Version Code** _____

Vision Care Insurance: Y / N **Insurance Company Name** _____

Reason for Today's Visit?

How did you Hear About us?

Medical History:
Do you have a history of any of the following? (Circle all that apply)

High Blood Pressure Diabetes
High Cholesterol Headaches
Sinus Problems Thyroid Disease
Do you smoke? Y / N

Medications and Vitamins:

_____
_____
_____
_____

Allergies? _____

Eye History: (Check all that apply)	**Self**	**Family**
Blurry Vision		
Glaucoma		
Macular Degen.		
Cataract		
Eye Turn		
Itchy Eyes		
Dry Eyes		
Eye Surgery		
Eye Injury		
Spots in Vision		
Flashes of Light		

Do you wear glasses? Y / N
Do you wear Contact Lenses? Y / N

Occupation:_____
Daily Screen Time (Computer, Tablet, Smartphone, and TV) _____ Hours

Did you know that we can now take a digital image of the back of your eye? This will become part of your medical record. Ask Dr. Patel or Dr. Gupta if this is right for you!

I authorize the release of relevant findings to either my family physician or my vision care insurer.

Signature: _____