The eye Studio
OPTOMETRY CLINIC

WELCOME TO OUR OFFICE

At The Eye Studio:

Our Mission Is to provide each patient with the highest quality of vision care.
Our Eye Care Team Is dedicated to you and your family's health and vision wellness.
We achieve this through personal attention, genuine enthusiasm and excellent service to deliver the eye care you deserve.
We Are Committed to providing state of the art vision care and the finest quality and most fashionable eyewear available.
Our Goal is to partner with you towards a lifetime of healthy vision.

PATIENT INFORMATION

Prefix: Last Name: First Name: DOB:
Street Address: City: Prov: Postal Code:
Home Phone: Alternative Phone: Email Address:
AHC # Gender Family Physician
Guardian's Name (if child) Occupation

Very Important! For New Patients Only:

To whom can we thank for Referring you to our Office? Name of Friend / Relative:
If you were not Referred, how did you choose our office?

INSURANCE INFORMATION

Please note in our Office we can only Direct Bill to: *Alberta Blue Cross, GreatWestLife, Greenshield,* and *Sunlife*

Plan # or ID: Group #: Do you participate in a flex or health spending account?
Primary Vision Insruance Coverage:
Susbscriber Last Name: Subscriber First Name: Subscriber DOB:

PATIENT HISTORY

What is the major purpose of this visit?

Is there any additional information we should know prior to the appointment? (For example: Disabilities or Medical Conditions)

Date of Last Eye Examination: Where?:

LIFESTYLE QUESTIONS

To help us provide you with the best vision, select any of the activities that apply to your lifestyle in work or pleasure:

☐ Indoor Sports ☐ Outdoor Sports ☐ Water Sports ☐ Flying ☐ Desk Work ☐ Reading

Do you…… (check box if your answer is yes)

☐ Want anything improved with your current glasses?
☐ Have East/West Commute?
☐ Prefer not to wear your glasses at times?
☐ Have interest in a "test drive" of the latest contact lens designs
☐ Want information on Laser Vision Correction surgery?
☐ Work at a computer? Hrs/week?
☐ Regularly spend time outdoors?
☐ Have more than 1 pair of current Rx eyewear?
☐ If you wear bifocals, do the lines or head tilting bother you?
☐ Have family members in need of eyecare?

CONTACTS & MEDICAL HISTORY

Have you had any eye surgeries? What kind and when?

CONTACTS HISTORY

Do you currently wear contacts? If you stopped wearing contacts, why?
How many days a week wearing contacts? What kind of contacts?
Is there anything you would like improved with your current contacts?

MEDICAL HISTORY

- this is optional, we will collect this information during our Pre-Testing process before the Exam

Family Medical History: *(Example: Father - cancer, Mother - glaucoma)*
Your Medical History: *(Example: diabetes, hypertention, stroke, thyroid)*
Your Medications: *(Example: any prescribed medications)*
Allergies:

Once you are finished completing this form, please save send this form to us via email info@theeyestudio.ca
If you are unable to email this document, please print and bring to your appointment.

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