WELCOME TO OUR OFFICE – ADULT

Name (Mr. / Mrs. / Ms. / Dr.): _____
(Last) (First)

Spouse / Emergency Contact: _____

Address: _____

City: _____ Province _____ Postal Code _____

Home phone # _____ Work phone # _____

Cell phone # _____ Email: _____

Date of Birth: _____/____/____ Age _____
Year Month Day

Occupation _____ Employer _____

Last Medical Exam _____ Family Doctor _____

Last Eye Exam _____ By _____

Do you wear contact lenses? Yes / No Hard / Soft

Are you taking any medications? Yes / No

Please List Medications _____

Medical Condition _____

Do you have any allergies? Please list: _____

How did you hear about our office? Were you referred? (Please give name)

Family Members / Friends _____

Family Dr. / Optometrist _____

School / Psychologist / Teacher _____

Phone book / Seminar / Internet _____

Alberta Health Care # _____

Blue Cross (if applicable) _____ Group # _____

WCB / Social Assistance / Health & Welfare Canada _____