WELCOME TO OUR OFFICE – CHILD

Name (Miss / Master): _____
(Last) (First)

Parent's Name(s): Mom _____, Dad _____

Address: _____

City: _____ Province _____ Postal Code _____

Home phone # _____ Work #'s Mom _____ Dad _____

Cell phone # _____ Parent's Email _____

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

School _____ Teacher _____ Grade ___

Last Medical Exam _____ Family Doctor _____

Last Eye Exam _____ By _____

Does your child wear contact lenses? Yes / No Hard / Soft

Is your child taking any medications? Yes / No

Please List Medications _____

Medical Condition _____

Does your child have any allergies? Please list: _____

How did you hear about our office? Was your child 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 _____