KINGSWAY EYE CARE
FAMILY OPTOMETRY

Registration Form

Name: Mr. Mrs. Ms. Dr. Prof.

First Last

Date of birth (mm/dd/yyyy) Month Day Year Age

OHIP # Version Code (last 2 letters)

Home Address Apt# City

Postal Code Contact # ( ) Cell Home Work

E-mail Occupation

Do you have school-aged children? Yes No If yes, age(s)

Computer usage a day hrs Amount of reading a day hrs Amount of driving a day hrs

Current vision correction

Distance Glasses Reading Glasses Bifocals Progressives (Invisible bifocals)

Prescription Sunglasses Contact Lenses Laser/Cataract Correction None

Do you experience any of the following?

Flashing Lights/Floaters Double Vision Watery Eyes

Sudden Vision Loss Headaches Irritated Eyes

Are you having difficult with any of the following?

Computer Reading

Television Driving

Please check all applicable medical conditions

Glaucoma Cataracts High Blood Pressure Diabetes Arthritis

Thyroid Disorder Lupus Allergies Other

What year was your last eye exam?

Current Medications

Family Doctor Phone #

Insurance Provider Policy # Member ID

Primary Card Holder Relationship to Card Holder

How did you hear about us?

Family/Friend Walking By Our Website Social Media

Doctor/Referral Other

In case of emergency, please notify (name and phone #)

By checking this box, I give my consnt to receive emails regarding appointment reminders, orders and other clinic related information.

By checking this box, I understand that I am responsible for all outstanding account balances.

Print Email Form