MEDICAL HISTORY AND NEEDS FORM

Hello _____,
First Name Last Name

Due to COVID-19, our office procedures have been enhanced for your safety. To ensure a safe and efficient visit for you, we require that you complete and submit this Medical History and Needs Form in the next 48 hours to guarantee your appointment.

Please also note that as part of our new safety measures, we have implemented a contactless pay system. This will ensure your visit to our office is both convenient and safe.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

"We" and "our" mean the following optometric practice: Eye Care First/Dr Hansel Huang Optometry Professional Corporation. READ CAREFULLY BEFORE SIGNING: By signing this form, you consent to our collection of the information above.

We collect, use and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services; to arrange payment for services; and as required by law.

The collection of this information is authorized by the *Health Insurance Act, Optometry Act, Regulated Health Professions Act* and *Health Protection and Promotion Act*. We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.

You may obtain access to your personal information stored by us in accordance with the *Personal Health Information Protection Act* by making a written request to: Dr. Hansel Huang, 2601 Lauzon Pkwy, Unit 510, Windsor, ON, N8T 3M4

If you would like to make a comment or complaint regarding the collection, use, disclosure or handling of your personal information you may contact: (519) 948-9797. You also have the right to complain to the Information Privacy Commissioner / Ontario, 1400-2 Bloor Street East, Toronto, ON M4W 1A8 (800-387-0073)

Thank you for your cooperation.

EyeCareFirst
BinocularVision&VisionTherapyServices

1. Patient information

Please fill out the following personal information

First Name*:	**Last Name*:**	**Email Address*:**		
Date of Birth: MM-DD-YYYY	**Address:** Address 1	Address 2		
Home Phone*: (###)- ###-####	City	State/Province	Zip/Postal Code	Country
Cell Phone: (###)- ###-####	**Preferred Method of Contact*:** Tell us the best way to reach you.	Email ☐	Phone ☐	Text ☐
Family Doctor: ❑Yes ❑No	**Family Doctor Phone Number:** (###)- ###-####	**Emergency Contact*:** First Name:	Last Name:	
Insurance Information*: Do you have insurance? ❑Yes ❑No ❑I am unaware of my insurance information.		Emergency Contact Phone Number: (###)- ###-####	Emergency Contact Email:	
Plan Name:	Policy #:	Group #:	Do you have dependant coverage? ❑Yes ❑No	
Credit Card Information (Not Mandatory):				
Card number:	Cardholder Name:	Expiry date:	Security Code:	
Billing Address:				
Health Card Information*:				
Health card number:		Expiry Date:		

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2. Personal medical history

Please list any medical conditions:

Have you been diagnosed with an eye disease?

Please list any previous eye surgeries:

Please list all medications you are currently taking:

Please list any Allergies:

Please list any eye diseases that run in your family:

3. COVID-19 health history

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? ❑ **Yes** ❑ **No**	Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? ❑ **Yes** ❑ **No**
Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19? ❑ **Yes** ❑ **No**	Have you travelled recently? ❑ **Yes** ❑ **No**

If you answered yes to any of these questions, please explain below.

_____

_____

_____

4. Purpose of your visit

Please describe your condition or purpose of your visit.

_____

_____

_____

5. Corrective lens information

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Do you wear the following?

Please check all that apply.

- ❑ Prescription Glasses
- ❑ Prescription Sunglasses
- ❑ Non-Prescription Sunglasses
- ❑ Contact Lenses
- ❑ I don't wear any of these

b) What do you use most of the time?

Please check all that apply.

- ❑ Prescription Glasses
- ❑ Prescription Sunglasses
- ❑ Non-Prescription Sunglasses
- ❑ Contact Lenses
- ❑ I don't wear any of these

6. Visual Needs

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Employment Information

Our eyes are also working. Please tell us what you do for work.

b) Job Description

Please describe your job duties to us.

c) Which do you do regularly?

Check all that apply.

- ❑ Night Driving
- ❑ Work Outdoors
- ❑ Commute 20+ min. By Car
- ❑ Work w/ Small Objects
- ❑ Work Under Fluorescent Light
- ❑ Read For Long Periods
- ❑ Work on a Computer
- ❑ Travel on Airplanes
- ❑ Watch TV for 3+ hrs/Day
- ❑ Work at a Desk
- ❑ Frequently Alternate Between Indoors & Outdoors

d) Hobbies/Recreation

To help us better understand how to use your eyes, please list any recreational activities or hobbies that you enjoy.

e) What do you like about your current glasses?

f) Is there anything you do not like about your current glasses?

g) What is important when choosing your new glasses?

Please check all that apply.

- ❑ Image
- ❑ Frame Material
- ❑ Fit
- ❑ Durability
- ❑ Weight
- ❑ Brand
- ❑ Fashion Trends
- ❑ Lens Type
- ❑ Lens Thickness
- ❑ Frame Colour
- ❑ Lens Colour
- ❑ Price

PLEASE BRING YOUR CURRENT GLASSES & SUNGLASSES TO YOUR EXAM

How did you hear about us?

- ❑ Family/Friend
- ❑ Google
- ❑ Website Appointment
- ❑ Walk In
- ❑ Family Doctor
- ❑ Other:

Thank you,

The Eye Care First Team

EyeCareFirst
Binocular Vision & Vision Therapy Services

FEE CONSENT FORM

I _____ hereby consent to:

- Providing my credit card information to enable Dr. Hansel Huang to set-up contactless payment for my visit.
- Providing my insurance company information
- Accepting payment receipts and optical prescriptions via email
- Providing my personal health information to ensure the time I spend in the office is efficient and focused on my medical care
- Being automatically charged a fee of $65 if I do not attend my appointment or cancel with fewer than 24 hours notice.

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I, _____ have read the information on this form and **DO** consent to the above.

Signed: _____ Date: _____

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