

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.

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Doctor Phone Number: (###)-###-####	Emergency Contact*: First Name:		Last Name:
Insurance Information*: Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am unaware of my insurance information.		Emergency Contact Phone Number: (###)-###-####		Emergency Contact Email:
Plan Name:	Policy #:	Group #:	Do you have dependant coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Credit Card Information (Not Mandatory):				
Card number:	Cardholder Name:	Expiry date:	Security Code:	
Billing Address:				
Health Card Information*:				
Health card number:		Expiry Date:		

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you travelled recently? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<p>a) Employment Information Our eyes are also working. Please tell us what you do for work.</p>	<p>b) Job Description Please describe your job duties to us.</p>												
<p>c) Which do you do regularly? Check all that apply.</p> <ul style="list-style-type: none"><input type="checkbox"/> Night Driving<input type="checkbox"/> Work Outdoors<input type="checkbox"/> Commute 20+ min. By Car<input type="checkbox"/> Work w/ Small Objects<input type="checkbox"/> Work Under Fluorescent Light<input type="checkbox"/> Read For Long Periods<input type="checkbox"/> Work on a Computer<input type="checkbox"/> Travel on Airplanes<input type="checkbox"/> Watch TV for 3+ hrs/Day<input type="checkbox"/> Work at a Desk<input type="checkbox"/> Frequently Alternate Between Indoors & Outdoors	<p>d) Hobbies/Recreation To help us better understand how to use your eyes, please list any recreational activities or hobbies that you enjoy.</p>												
<p>e) What do you like about your current glasses?</p>	<p>f) Is there anything you do not like about your current glasses?</p>												
<p>g) What is important when choosing your new glasses? Please check all that apply.</p> <table border="0"><tr><td><input type="checkbox"/> Image</td><td><input type="checkbox"/> Fashion Trends</td></tr><tr><td><input type="checkbox"/> Frame Material</td><td><input type="checkbox"/> Lens Type</td></tr><tr><td><input type="checkbox"/> Fit</td><td><input type="checkbox"/> Lens Thickness</td></tr><tr><td><input type="checkbox"/> Durability</td><td><input type="checkbox"/> Frame Colour</td></tr><tr><td><input type="checkbox"/> Weight</td><td><input type="checkbox"/> Lens Colour</td></tr><tr><td><input type="checkbox"/> Brand</td><td><input type="checkbox"/> Price</td></tr></table>		<input type="checkbox"/> Image	<input type="checkbox"/> Fashion Trends	<input type="checkbox"/> Frame Material	<input type="checkbox"/> Lens Type	<input type="checkbox"/> Fit	<input type="checkbox"/> Lens Thickness	<input type="checkbox"/> Durability	<input type="checkbox"/> Frame Colour	<input type="checkbox"/> Weight	<input type="checkbox"/> Lens Colour	<input type="checkbox"/> Brand	<input type="checkbox"/> Price
<input type="checkbox"/> Image	<input type="checkbox"/> Fashion Trends												
<input type="checkbox"/> Frame Material	<input type="checkbox"/> Lens Type												
<input type="checkbox"/> Fit	<input type="checkbox"/> Lens Thickness												
<input type="checkbox"/> Durability	<input type="checkbox"/> Frame Colour												
<input type="checkbox"/> Weight	<input type="checkbox"/> Lens Colour												
<input type="checkbox"/> Brand	<input type="checkbox"/> Price												
<p>PLEASE BRING YOUR CURRENT GLASSES & SUNGLASSES TO YOUR EXAM</p>													
<p>How did you hear about us?</p> <table border="0"><tr><td><input type="checkbox"/> Family/Friend</td><td><input type="checkbox"/> Walk In</td></tr><tr><td><input type="checkbox"/> Google</td><td><input type="checkbox"/> Family Doctor</td></tr><tr><td><input type="checkbox"/> Website Appointment</td><td><input type="checkbox"/> Other:</td></tr></table>		<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Walk In	<input type="checkbox"/> Google	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Website Appointment	<input type="checkbox"/> Other:						
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Walk In												
<input type="checkbox"/> Google	<input type="checkbox"/> Family Doctor												
<input type="checkbox"/> Website Appointment	<input type="checkbox"/> Other:												

Thank you,

The Eye Care First Team

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 \$90 if I do not attend my appointment or cancel with fewer than 24 hours notice.

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)

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

Signed: _____ Date: _____