Velore EyeCare
2960 Kingsway Drive
Kitchener, ON, N2C 1X1
Tel: 548-889-7777 | Fax: 548-488-5072

PATIENT INTAKE INFORMATION FORM

Welcome to Velore EyeCare. Thank you for taking the time to complete this form as thoroughly as possible. The information you provide will help us better understand your vision needs and deliver the highest quality of eye care.

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City _____ Postal code: _____

Cell phone: _____ Email: _____ Occupation: _____

Preferred communication method: ☐ Phone ☐ Email ☐ Text

Emergency Contact Name: _____ Relationship: _____ Emergency Contact Phone: _____

Reason for today's appointment: (Please check all that apply)

☐ Routine eye exam /Ocular health assessment ☐ New glasses ☐ Vision Changes

☐ Interested in contact lenses ☐ MTO Driver's Form ☐ Other _____

Do you wear: ☐ Glasses ☐ Contact Lens ☐ Both ☐ None

When was your last full eye exam? (estimate) _____

Did you or any of your blood relatives have any of these conditions? (Please choose **NO** if condition does NOT apply to you)

Medical History	Self	Relative	none
Diabetic	☐	☐	☐
High blood pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Thyroid Problems	☐	☐	☐
Heart Disease	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Artritis	☐	☐	☐
Other: _____			

Ocular History	Self	Relative	none
Glaucoma	☐	☐	☐
Cataract	☐	☐	☐
Retinal Disease	☐	☐	☐
Eye Injury	☐	☐	☐
Eye Surgery	☐	☐	☐
Lazy Eye	☐	☐	☐
Blindness	☐	☐	☐
Other: _____			

	YES	NO	
Do you see double?	☐	☐	
Frequent Headaches?	☐	☐	
Are you Pregnant?	☐	☐	
Are you Nursing?	☐	☐	
Eyes Been dilated?	☐	☐	Year: ____
Do you smoke?	☐	☐	
Former Smoker?	☐	☐	

Family Dr Name:
_____

Current medications (including eye drops):

_____

Do you have allergies to any medications or foods? ☐ NO ☐ YES Please list: _____

PHIPA Privacy Notice / Consent: By signing below, I acknowledge that Velore EyeCare collects, uses, and discloses my personal health information for the purpose of providing optometric care and related services, including assessment, diagnosis, treatment, referrals to other healthcare professionals when necessary, appointment scheduling and reminders, and processing insurance or vision benefit claims. I understand that my personal health information will be handled in accordance with the Personal Health Information Protection Act (PHIPA) and will only be used or disclosed as required for my care or as permitted or required by law. I acknowledge that I have been informed that Velore EyeCare maintains a Privacy Policy describing how my personal health information is protected and how I may access or request correction of my records. By signing below, I confirm that the information I have provided is accurate to the best of my knowledge and I consent to the collection, use, and disclosure of my personal health information for the purposes described above.

_____ _____

Patient Signature or Patient's Legal Representative Date