Medical Questionnaire

Welcome to the optometry office of Dr. Michael Lee.
As a new patient to the office, allow us to get to know you better.

LAST NAME _____ FIRST_____ M.I _____
(MIDDLE INITIAL)

ADDRESS_____ _____ _____ _____
APT# STREET # AND NAME CITY POSTAL CODE

CELL_____- _____- _____ BUS. _____- _____- _____ X _____ HOME _____- _____- _____
PLEASE CIRCLE YOUR PRIMARY FORM OF COMMUNICATION

OHIP# _____ - _____ EXP _____/_____/_____ GENDER: M W NB
FOR SPECIALIST REFERRALS VERSION CODE MM DD YYYY

DATE OF BIRTH _____ /_____ /_____ ____
MM DD YYYY AGE

EMAIL: _____

□ I consent to be contacted via email/phone to remind me about my appointments, recalls, contact lens orders, or in case of specialist referrals.

DATE OF LAST EYE EXAM: ____/____/____ DATE OF LAST MEDICAL EXAM: ____/____/____
MM DD YYYY MM DD YYYY

_____ _____
FAMILY DOCTORS' NAME TELEPHONE/ FAX NUMBER OR ADDRESS

ARE YOU PREGNANT? Y N DO YOU SMOKE? Y N

OCCUPATION: _____

MEDICAL CONDITIONS FOR YOU: (Please Circle)

Heart Disease	Autoimmune disease	Cancer
Macular Degeneration	High Cholesterol	Liver disease
Diabetes	Sickle cell disease	Thyroid disease

Other: _____

MEDICAL CONDITIONS IN THE FAMILY: (Medical or Ocular)

_____

ALLERGIES: _____

MEDICATIONS: (Prescribed or OTC)

_____

DO YOU WEAR CONTACT LENSES? Y N TYPE:

OCULAR HISTORY: (Please Circle)

Cataracts	Macular Degeneration	Eye Turn	LASIK/PRK
Glaucoma	Retinal Detachment	Lazy Eye Cataract surgery	

Other: _____

WHERE DID YOU HEAR ABOUT US FROM? (Please Circle)

Friend Family Internet Other: _____

Consent Form

I _____ hereby consent to:

- ☐ Providing my insurance company information to set up direct billing
- ☐ 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 **$50** if I do not attend my appointment or cancel with fewer than 24 hours' notice
- ☐ I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days.
- ☐ I understand that this business and my optometrist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation by the health history provided by each patient

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

"We" and "our" mean the following optometric practice: Dr. Lee Optometry and Specs on Bloor

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 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. Lee Optometry.

If you would like to make a comment or complaint regarding the collection, use, disclosure or handling of your personal information you may contact Dr. Lee Optometry

You also have the right to complain to the Information Privacy Commissioner/Ontario, 1400-2 Bloor St. East, Toronto, ON M4W 1A8 (1-800-387-0073)

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

Signed: _____ Date: _____