Howlett OPTICAL
REGISTRATION FORM

Please Print

PATIENT INFORMATION

Patient's first name:	Last name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.

Home Phone: ( )	Work Phone: ( )	Occupation:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Mailing address:	Apt#

City:	Province:	Postal Code:

Email: Used for updates on your eye care services	Family Doctor / Clinic:

I authorize the optometrist to exchange medical information with other health care providers as he/she deems necessary to provide the best possible care. ☐ Yes ☐ No

Chose clinic because/referred to by **(please check one box)**: ☐ Insurance Plan ☐ Yellow Pages ☐ Web-Site

☐ Family ☐ Friend ☐ Facebook/Twitter ☐ Close to home/work ☐ Returning Patient ☐ Other

MEDICAL HISTORY

Date of last eye exam: / /	What is your reason for today's visit?

Do you wear contact lenses? ☐ Yes ☐ No — How many hours per day do you wear your contacts?

What type of Contacts do you wear? (check all that apply)	☐ Soft lenses	☐ Toric	☐ Disposable
	☐ Rigid gas permeable	☐ Daily wear (daytime only)	☐ Extended wear (sleep in)

How often do you change your contact lenses?

Do you or your family members have any of the following medical or eye conditions? If so, please list who:

☐ High blood pressure	☐ Diabetes	☐ Allergies	☐ Thyroid problem	☐ Other Medical Conditions
☐ Glaucoma	☐ Retina Disease	☐ Cataract	☐ Amblyopia (lazy eye) / Strabismus (eye turn)	☐ Macular Degeneration

ARE YOU CURRENTLY TAKING ANY MEDICATION? (Please list)

Have you ever experienced? (check all that apply)

☐ Color vision problems	☐ Double vision	☐ Flashes of light	☐ Floaters
☐ Night vision problems	☐ Eye infection	☐ Eye surgery	☐ Frequent headaches

How many hours do you work on computer per day?

Do you smoke? ☐ Yes ☐ No — (Women only) Are you pregnant or nursing? ☐ Yes ☐ No

DILATION INFORMATION

To provide the most complete evaluation of your eyes it is sometimes necessary to administer drops to dilate your pupils. The optometrist will discuss how the dilation may **temporarily affect** your vision. Please check on of the following:

☐ I give my permission to have my eyes dilated ☐ I am undecided and would like to discuss ☐ I understand the importance of Dilation, but refuse procedure

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance Provider:	Policy Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Howlett Optical or insurance company to release any information required to process my Claims.

Patient/Guardian signature _____ **Date** _____