NEW PATIENT REGISTRATION FORM

Name (Mr. / Mrs. / Miss / Ms./ Dr.:		
Date of birth: (dd) (mm) (yr)	OHIP #:	
☐ Home Phone:	☐ Work Phone:	Ext.:
☐ E-mail:	☐ Cell Phone:	
Please check mark the best way to contact you.		
Street Mailing address:		
City:	Postal Code:	
Occupation / Grade :	Employer / School:	
Spouse / Guardian:	Vision Insurance Company:	
Family Doctor:	Last Medical Doctor's Appointment	
Previous Optometrist:	Last Eye Exam	
Reason for this Appointment:		
Do you currently wear glasses ☐ Yes ☐ No	Do you currently wear contact lenses ☐ Yes ☐ No	