Willowbrook Optometry
Intake Form – Adult Patients

Patient Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ Prov: _____ Postal code: _____
CareCard Number: _____ Family Doctor: _____

Cell Phone Number: _____ Secondary Phone Number: _____
Text Reminders: Yes ☐ No ☐ Email: _____

Last Eye Exam: _____

Concerns with eyes/vision: _____
Medications: _____
_____
Allergies: _____
Medical conditions: _____
_____
Eye injuries, surgery,
Or disease (self or family): _____

Are you *Pregnant* **or** *Nursing***? Yes ☐ No ☐**

Do you see an *Ophthalmologist***? Yes ☐ No ☐**
If yes, *Name of Specialist***:** _____

Do you wear Glasses? **Yes☐ No☐** If so, *how old are they*? _____

Do you wear Contact Lenses? **Yes ☐ No ☐**
If Yes, *what Brand do you wear?* _____
Also, *are your lenses comfortable at the end of your day?* Yes ☐ No ☐

If No, *are you interested in getting more information about contact lenses?* Yes ☐ No ☐

Extended Health
We work with the following providers:
Great West Life, Sunlife, Pacific Blue Cross, Medavie Blue Cross, VAC, Greenshield/SSQ, Johnson Inc, Industrial Alliance, Maximum Benefit, Chambers of Commerce Group Insurance and Manulife.

Extended Health Insurance Provider: _____
Members Name: (First) _____(Last) _____ (Date of Birth) _____
Policy/Provider number**:** _____ Member ID**:** _____

Relationship to Member**:** Self ☐ Spouse ☐ Full Time Student ☐