HERZIG EYE INSTITUTE

PATIENT REGISTRATION FORM

First Name:		**Last Name:**	
Address:			
City:	**Postal Code:**	**Country of Residence:**	
Date of Birth (MM/DD/YY):		**Age:**	**Gender:**
Health Card #:		**Version Code:**	
Home #:	**Business #:**	**Cell #:**	
Email address:			
Employer Name:			
Emergency Contact Person Name:			**Phone:**
Family Doctor:	**PH:**		**FAX:**
Eye Doctor:	**PH:**		**FAX:**
Has your doctor sent a referral for you? ☐YES ☐NO **May we contact your eye doctor?** ☐YES ☐NO			
Approximate date of last eye examination:			
Are you here for a surgical second opinion on a procedure done elsewhere? ☐YES			
Why did you choose Herzig Eye Institute today?			

How Did You Hear About Us?

☐Family / Friend		☐Optometrist	
☐HRPA Member		☐Ophthalmologist	
☐Website		☐Medical Doctor	
☐Event		☐Executive Health Program	
☐TV/Radio		☐Other	

I understand and agree to the following:

- **Laser vision correction & refractive consultations:** This comprehensive consultation is to determine candidacy for a custom vision correction procedure. It does not substitute for an annual eye exam. Laser vision correction & refractive procedures are not insured by OHIP. Other services provided may be a benefit of OHIP.
- **Cataract & General consultations:** Some services may not be insured by OHIP. Fees will apply.
- Fees will apply for a copy of my records or transferring my information to another doctor.
- There is a **$200 fee** for surgical second opinions.

In an effort to stay connected and provide important information about health and safety, services we offer, events, news items, product care and promotions, occasionally we would like to send you email updates. ☐ I agree to receive these emails and understand that I can unsubscribe at any time.

Date:_____

Patient Name:_____ **Patient Signature**: _____

(May be signed at time of consultation)

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Medical History		
Drug Allergies:	☐YES ☐NO List:	
Medications (List all):		
For what conditions are you taking medications?		
Major surgery in the last 10 years (List)		
Drops/Ointments:	Type:	How Often:
Pregnant?	☐YES ☐NO ☐Trying	Breastfeeding? ☐YES ☐NO

Ocular History

Contact Lens Wear: ☐Soft ☐Soft Toric ☐Rigid Gas Permeable
Date contacts last worn:
Difficulty wearing for long periods of time? ☐YES ☐NO

☐Wear Reading Glasses

Personal Eye History

☐Light Sensitivity
☐Keratoconus
☐Strabismus or Amblyopia
☐Glaucoma
☐Cataracts
☐Macular Degeneration
☐Retinal Tear / Detachment
☐Retinal Laser Treatment or Injections
☐Eye Disease Specify:
☐Eye Surgery Specify:
How long ago?

Family Eye History

☐Keratoconus
☐Cataracts
☐Eye Surgery Specify:
☐Eye Disease Specify:

Dry Eyes - Severity of Symptoms Scale (Without Contact Lenses)

0=No problems 1=Tolerable 2=Uncomfortable 3=Bothersome 4=Intolerable

	Rating		Rating
Dryness, Grittiness or Scratchiness		Difficulty Opening eyes in AM	
Tearing or Watery Eyes		Intermittent blurring	
Burning			

Payment Plans

Are you interested in learning more about payment plan options? ☐YES

Privacy Statement

The Herzig Eye Institute collects personal information for the purpose of identifying and treating patients and their medical conditions. Personal information is protected in accordance with the directives outlined in the Personal Information Protection and Electronic Documents Act (PIPEDA) and will not be distributed without the patients written consent or used for purposes beyond that for which it was collected.

HERZIG
EYE INSTITUTE

Lifestyle Questionnaire

Please take a moment to answer some questions about yourself. These questions will help us determine which custom procedure is best suited to your individual needs and lifestyle.

Name: _____

Date: _____

How many hours per day do you spend:

_____ Driving
_____ On computer
_____ Reading books or phone

What is (was, if retired) your occupation?

Please list your favourite hobbies:

What is **motivating** you to consider custom vision correction at this time?

How would you best describe your personality:

- ☐ Easy Going
- ☐ Somewhat Easy Going
- ☐ Balanced
- ☐ Somewhat Perfectionist
- ☐ Perfectionist

For Eyes Over 40 Only:

Even though you may currently need glasses, surgery gives you the option of seeing better without glasses. This means you could wear glasses less often. Which of the following best describes what you would like after surgery?

- ☐ I want to wear glasses as little as possible
- ☐ I'm okay having to wear glasses some of the time

Think of your vision in terms of three zones:

- Distance (driving, tv, golf, tennis)
- Mid-range (computer, cooking, gardening)
- Near (reading, cell phone, sewing, make-up)

If you had to wear glasses for at least one zone after surgery, for which zone would you be more willing to wear glasses?

- ☐ Distance vision
- ☐ Mid-range/Near Vision

Please check the single statement that best describes you in terms of night vision:

- ☐ Night vision is extremely important to me, and I require the best night vision possible.
- ☐ Night vision is not particularly important to me.
- ☐ I want to drive comfortably at night, but I would tolerate some slight imperfections such as glare or haloes

Where are you most comfortable holding your reading material:

- ☐ close to face
- ☐ chest level
- ☐ lap level