1. Consent Form

I _____ hereby consent to:

- Providing my credit card information to enable Eyes on Avenue to set-up contactless payment for my visit.
- Providing my insurance company information
- Accepting payment receipts and optical prescriptions via e-mail
- 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 **$50.00** if I do not attend my appointment or cancel with fewer than 24 hours notice.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT
"We" and "our" mean the following optometric practice: Eyes on Avenue

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 Health Protection 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: info@eyesonavenue.com

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

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

Signed: _____ Date: _____

2. Patient information

Please fill out the following personal information.

First Name*	**Last Name***	**Email Address***	
Date of Birth (MM/DD/YYYY)*	**Address 1**	Address 2	
Home Phone*	**City**	**Province**	**Postal Code**
Cell Phone:	**Preferred Method of Contact*** Tell us the best way to reach you (e.g., e-mail, cell phone, home phone)		
Family Doctor Name:	**Family Doctor Phone Number:**	**Emergency Contact*** Name:	Phone Number:

Insurance Information:			
Plan Name:	Policy #:	Group #	Do you have dependent coverage? ☐ **Yes** ☐ **No**
Secondary Coverage: relationship to cardholder	*□ spouse*	*□ parent/child*	*□ dependent*
Plan Name:	Policy #:	Group #:	Cardholder's Date of Birth:
Health Card Information:			
Health card number:		Version Code (2-letters)	Expiry Date:

3. Personal medical history

Please list any medical conditions (e.g., hypertension, diabetes, history of cancer, etc.)

Have **you** or a **family member** been diagnosed with an eye disease? (please list condition and relationship)

Please list any previous eye surgeries:

Please list all medications you are currently taking:

4. COVID-19 health history

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? ☐ **Yes** ☐ **No**	Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? ☐ **Yes** ☐ **No**
Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19? ☐ **Yes** ☐ **No**	Have you travelled in the last 14 days? ☐ **Yes** ☐ **No**

If you answered yes to any of these questions, please explain below:

5. Purpose of your visit

Please describe your condition or purpose of your visit:

6. Corrective Lens Information

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Do you wear the following?
Please check all that apply

- ☐ **Prescription Glasses**
- ☐ **Prescription Sunglasses**
- ☐ **Non-Prescription Sunglasses**
- ☐ **Contact Lenses**
- ☐ **I don't wear any of these**

B) What do you use most of the time?
Please check all that apply

- ☐ **Prescription Glasses**
- ☐ **Prescription Sunglasses**
- ☐ **Non-Prescription Sunglasses**
- ☐ **Contact Lenses**
- ☐ **I don't wear any of these**

7. Visual Needs

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs

a) **Occupation** Our eyes are also working, please tell us what you do for work	b) Which do you do regularly? ☐ **Night driving** ☐ **Work Outdoors** ☐ **Commute 20+ min. by Car** ☐ **Work with small objects** ☐ **Read for long periods** ☐ **Work on a computer** ☐ **Work at a desk** ☐ **Frequently alternate between indoors & outdoors** ☐ **Frequently alternate between near & distance viewing**
c) **Hobbies/Recreation** To help us better understand how you use your eyes, please list any recreational activities or hobbies that you enjoy.	d) Do you have any issues with your vision at this time? ☐ **Yes** ☐ **No** g) Would you like us to schedule you some time with our optician to look at glasses or contact lenses today? ☐ **Yes** ☐ **No**
PLEASE BRING YOUR CURRENT GLASSES & SUNGLASSES TO YOUR EXAM **YOUR PUPILS MAY BE DILATED.**	
How did you hear about us? ☐ Family/Friend ☐ Google ☐ Website Appointment ☐ Walk In ☐ Family Doctor ☐ Other:	