DR. MINESH KUTLERYWALA & ASSOCIATES

Welcome To Our Office

Patient Information

Name: _____ **D.O.B** ___/____/_____ **Age:** _____ Sex**:** M | F

Mstr. / Mr. / Mrs. / Miss. / Dr. **DD MM YYYY**

Mailing Address: _____

City:_____ **Province**:_____ **Postal Code**: _____ **Occupation:**_____

AHC#: _____ **Email Address**: _____**(for appt reminders and contacts only)**

Phone: (Cell): _____ _____ **(Home):** _____ _____ **(Work)** _____ _____

How did you hear about our office? (Please check the appropriate box)

❑ **LensCrafters** ❑ **Sears Optical** ❑ **Family/Friends** ❑ **Yellowpages** ❑ **Online** ❑ **Walk-In** **Other:** _____

When was your last eye exam? _____ Name of Optometrist Office _____

Are you planning on purchasing glasses today? YES I NO

If you are covered by Social Services, AISH or Indian Affairs please provide proof of coverage prior to exam.

CONTACT LENSES:

Do you currently wear contact lenses? **YES I NO** If so, are you happy with the comfort of your contacts? **YES I NO**

If not, are you interested in trying contacts? **YES I NO**

MEDICAL HISTORY

Me (Yourself), **M** (Mother), **F** (Father), **GM** (Grandmother), **GF** (Grandfather), **B** (Brother), **S** (Sister)

*Since certain conditions are hereditary, it is ***important*** that we know you and your families health history to better care for your vision:

Arthritis ___	Asthma/Lung Problems ___	Eye Surgery ___	Macular Hole ___
Cancer/Tumors ___	High Cholesterol ___	Cataracts ___	Retinal Detachment ___
Diabetes Type I or II ___	HIV ___	Crossed Eyed ___	Other (please state): _____
Heart Condition ___	Hepatitis ___	Flashes ___	_____
High Blood Pressure ___	Thyroid ___	Glaucoma ___	_____
Low Blood Pressure ___	Other (please state): _____	Lazy Eye (Amblyopia) ___	
Multiple Sclerosis ___	_____	Color Vision Loss ___	
Stroke ___	_____	Macular Degeneration ___	

List any of Medications_____

_____

List any Allergies_____

The above information is truthful and to the best of my knowledge.

I understand that I am responsible for all fees charged, and if AHC rejects any claims I will pay the full amount.

Patient or Guardian Signature: _____Date:_____

Emergency Contact:_____ Relationship _____ Phone Number:_____