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YORK FINCH
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PATIENT REGISTRATION FORM

TODAY'S DATE___________________

PATIENT INFORMATION

Mr. Mrs. Miss. Ms. Dr. Fr.
SURNAME ____________________________**FIRST NAME**____________________________

DATE OF BIRTH (mm/dd/yy)_______/________/________

ADDRESS____**CITY**_______________________________________

PROVINCE________**POSTAL CODE**_______________**EMAIL**____

PHONE#__________________________/__________________________/__________________________
(HOME) (BUSINESS) (CELL)

OCCUPATION___________________________________

MEDICAL HISTORY

FAMILY DOCTOR NAME ____________________________

CURRENT MEDICAL CONDITIONS:
☐ NONE ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ CHOLESTEROL ☐ ARTHRITIS
☐ HEART DISEASE ☐ OTHER:____

CURRENT MEDICATIONS:

ALLERGIES:
☐ NO ☐ YES:____

OCULAR HISTORY

PERSONAL AND OR FAMILY HISTORY OF:
☐ GLAUCOMA ☐ MACULAR DEGENERATION ☐ STRABISMUS/AMBLYOPIA
☐ RETINAL DETACHMENT ☐ OTHER:____

PAST OCULAR SURGERIES:
☐ NO ☐ YES:____

THANK YOU FOR COMPLETING OUR PATIENT REGISTRATION FORM.