

Date \_\_\_\_\_ **AHC#:** \_\_\_\_\_

Name: Mr. Mrs. Miss Ms Dr. \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

Address: \_\_\_\_\_

City:/Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone No. (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

**EMAIL:** \_\_\_\_\_ Preferred method of contact:  Email  SMS  Phone

\*Emails are used solely for appointment reminders and in office promotions. Your email will not be sold or used for any other purposes.

I consent to receive emails for the above purposes.

\_\_\_\_\_  
Signature

Occupation: \_\_\_\_\_

Were you referred to our office?  Yes  No

If yes, whom can we thank? \_\_\_\_\_

If no, how did you hear about us? \_\_\_\_\_

OR:  Family Member  Website  Physician  TV/Radio Ad  Walking by  Google/Internet

Do you currently use (please check all that apply)?

- |  |   |
|--|---|
| <input type="checkbox"/> Glasses full time | <input type="checkbox"/> Bifocals/progressive bifocal |
| <input type="checkbox"/> Glasses part time | <input type="checkbox"/> Contact lenses               |
| <input type="checkbox"/> Reading glasses   | <input type="checkbox"/> None                         |

How old are the glasses? \_\_\_\_\_

Would you like more information on:

- |   |  |
|---|--|
| <input type="checkbox"/> Anti-reflective lenses   | <input type="checkbox"/> Thinner/lighter lenses    |
| <input type="checkbox"/> Transition lenses        | <input type="checkbox"/> Sports glasses            |
| <input type="checkbox"/> Eye drops/dry eye        | <input type="checkbox"/> Disposable contact lenses |
| <input type="checkbox"/> Scratch resistant lenses | <input type="checkbox"/> Sunglasses                |
| <input type="checkbox"/> Computer glasses         | <input type="checkbox"/> Eye vitamins              |
| <input type="checkbox"/> Bifocal contact lenses   | <input type="checkbox"/> Other: _____              |

Do you currently have optical coverage?  Yes  No If yes, with which company \_\_\_\_\_