Welcome to Prism Eye Institute™! Prism Eye Institute™ provides emergency eye care in addition to our regularly scheduled patient visits. In some cases emergency patients may be seen ahead of you based on the severity of their eye problems. Be assured that every effort will be made to see you at your scheduled appointment time. As Prism Eye Institute™ is also a teaching facility you may encounter medical students, optometry students, residents, and other doctors in training during your appointments. We aim to provide the best care possible to our patients and we will do our best to make your visits as smooth and pleasant as possible. Thank you for your understanding.

PLEASE COMPLETE BOTH SIDES OF THIS PATIENT INFORMATION FORM

Last Name		**First Name**	
Address		**Sex:**	**□ M** **□ F**
No.	**Postal Code**	**Birth Date (yyyy / mm / dd):**	
Street		**Health Card #:**	
City:		**Health Card Version Code:**	
Telephone		**Do you have private health ins.?**	**□ Yes** **□ No**
Home:		**Referring Doctor:**	
Work:			
Mobile:		**Family Doctor:**	

Do you have or have you had any of the following (indicate "yes" or "no" for each)?

Health History	Yes	No	Eye History	Yes	No
Aneurysms			Cataracts		
Arthritis			Corneal Disease		
Asthma			Glaucoma		
Carotid Artery Disease			Iritis		
Diabetes			Retinal Surgery / Injury		
Epilepsy / Seizures			Strabismus (Crossed / Lazy Eyes)		
Head / Spinal Injuries			Other Eye Conditions – indicate:		
Heart Disease / Heart Attack			Cataract Surgery		
Hepatitis			Cataract Surgery Dates – Right: Left:		
High Blood Pressure			Laser Surgery		
HIV / Aids			Laser Surgery Dates – Right: Left:		
Kidney Disease			**Family History (blood relative) indicate relationship, (e.g., Mother, Father, Brother, Sister, Aunt, Uncle, etc.)**		
Latex Allergy					
Migraines			Cataracts:		
Nervous / Psychiatric Disorders			Glaucoma:		
Sickle Cell Anemia			Macular Degeneration:		
Skin Disease / Disorders			Retinitis Pigmentosa:		
Sleep Apnea			Strabismus (Crossed / Lazy Eyes)		
Stroke			Other:		
Tuberculosis			**Is your visit related to a worker's compensation claim?**		
Ulcerative Colitis / Crohn's Disease			**□ Yes** **□ No**		

Medications (Please list all medications that you are currently taking):
Allergies (Please list):

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Please Read This Notice Carefully

This form must be signed before you receive care in our clinic.

Research at Prism Eye Institute™

Prism Eye Institute™ believes that research is an essential part of being able to provide our patients the best care possible. Many of our doctors are involved in research projects that aim to improve vision care. As such you may be invited to take part in research projects.

In some cases, our research looks backwards to provide a better understanding of our current treatment practices. In these cases we may look into your medical record for information.

Participation in any research is always voluntary and you can of course decline to take part. Participation in research does not diminish your rights as a patient in any way. Personally identifying information such as your name, address, telephone number and OHIP number is never collected or used as part of any research work.

Release of Medical Information

Your privacy is important to us. In accordance with laws of the Province of Ontario regarding personal health information (*Personal Health Information Protection Act, 2004*), Prism Eye Institute™ may collect, use and release personal health information only with your permission. All information provided will be kept strictly confidential unless you provide a written request to release your information to a specific party, or as required by law. The information collected in this registration form will assist us to provide safe and effective treatment and care for your condition. Your written permission is required in order to obtain or release information to your other health care professionals.

Consent to the Collection, Use and Disclosure Of Personal Health Information

I understand that the office will only collect, use and disclose my personal health information with my consent (as set out in its privacy policy) unless a particular collection, use or disclosure is permitted or required by law without my consent.

I also understand that I may decline to sign this consent form. I may also withdraw my consent any time in writing. By declining to sign this form or withdrawing consent, I further understand that Prism Eye Institute™ may decline to continue to provide me ongoing care in its facilities beyond emergency and urgent care until a suitable alternate provider is identified.

I authorize the release my personal health information to, and to obtain medical/health records from insurance providers (as applicable – OHIP and/or private insurance) and health care professionals concerned with my care at Prism Eye Institute™.

_____	_____	_____
Patient Name	Patient Signature	Date (dd/mm/yyyy)
_____	_____	_____
Guardian/Interpreter Name	Guardian/Interpreter Name	Date (dd/mm/yyyy)

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