



Dr. Hernando Chacon-Andrade
Eye Physician and Surgeon

NEW PATIENT REGISTRATION

Information provided will be used solely in the provision of your medical eye care

LAST NAME _____

MALE ☐ FEMALE ☐

FIRST NAME _____

Mr. ___ Ms. ___ Mrs. ___ Miss ___ (Optional)

MIDDLE NAME _____

Parent or Legal Guardian _____

Birthdate Day ___ Month ___ Year ___

Home Phone Number (___) ___ - _____

Address _____

Work or Cell Number (___) ___ - _____

City _____ Province _____

Postal Code _____

Family Doctor _____

HEALTH CARE NUMBER _____

Optometrist _____

Do WE have *permission* to share our examination findings with your Doctor or Optometrist? YES ☐ NO ☐

Emergency Contact Name _____

Emergency Phone Number (___) ___ - _____

MEDICAL HISTORY

Existing Eye Conditions or previous Eye Surgery

Existing Medical Conditions or previous General Surgery

Family History of Ocular Conditions

Current Medications (you can attach a list)

Current Eye Drops _____

Medication Allergies

Latex Allergy ☐ yes ☐ no

I hereby certify that above information is *complete* and *correct* to the best of my knowledge

Signature _____

Date _____

Please note, if you have a **routine Eye Examination** (Your eye problems are not related to a medical condition) and you are between the ages of 19 and 64, the examination is not covered by Health Care. The fee for this examination is \$150.00 and will be invoiced at the conclusion of your appointment.