PERSONAL AND CONFIDENTIAL INFORMATION

Dr. Mann & Associates

PLEASE PRINT CLEARLY

Full Name: ______________________ **Date of Birth:** ______________

Full Address: ______________ **City:** ______________ **Postal Code:** ______________

Home Phone #: ______________________ **Current Cell#:** ______________

Email Address: ____

Preferred method of Contact: ______________________________________

OHIP Card: ______________________ **Version Code:** ______________

***Patients covered by OHIP 19yrs-under 65yrs and over**

Current Insurance: Policy members Name and DOB: ______________________

Insurance Company name: ______________ **Policy:** ______________ **ID:** ______________

Amount of coverage: $ ____

Occupation: ______________ **Family Doctor:** ______________ **Tel:** ______________

- **Do you wear contact lenses?** Yes No
  If yes, did you sign the consent form? Yes No
- **Would you be interested in trying contacts?** Yes No
- **Do you wear glasses?** Yes No
- **Is your driver's license restricted?** Yes No
- **Do you have sunglasses with you today?** Yes No
- **Are you on any medications? (please list below)** Yes No

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- **Do you have any vision concerns?(please list below) Yes No**

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Signature: ____

Thank you for your kind co-operation as we update your file.

Dr. Mann & Associates