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.