Brass Monocle
EYEWEAR

Dr. Shelly Taneja, Optometrist

PATIENT INFORMATION (Please Print) Today's Date:_____

Title (Please circle): Dr. Mr. Mrs. Miss. Ms. Child**

Patient's Name:_____
(Last) (First) (Middle)

If Minor, Parent's Name:_____
mm/dd/year (Last) (First) (Middle)

Birth Date:_____ Alberta Health Care # _____ Sex (Please circle) M or F

Address: _____
(Number & Street, Apt #) City/State Zip

Phone: Home (____)_____ Day (____)_____

Cell (____)_____ E-Mail _____

Occupation: _____

Employer: _____ How did you hear about us: _____

INSURANCE INFORMATION

Insurance Provider:_____ Member ID# _____

Policy # _____ Group ID # _____

Is the patient the primary insured? ☐ No ☐ Yes

(If no, please complete the Primary Insured Information section below.)

** Children ages 15 and younger must be accompanied by a parent/guardian or an adult with consent for examination. Children 16 and up to age 18 must have written or verbal consent from parent/guardian.

All insurance patients: The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision insurance. By signing below, you authorize payment of insurance benefits to Dr Shelly Taneja & Brass Monocle. You will be financially responsible for any balance not paid by insurance. Professional fees are non-refundable.

Parent/Guardian Signature _____ Date _____

Returning Patients: If there is no change to above information, please sign and date below.

_____ Date_____

PERSONAL EYE HISTORY

Reason for today's visit: _____

Do you wear glasses? ☐ No ☐ Yes Contact lenses? ☐ No ☐ Yes

Have you worn contact lenses in the past? ☐ No ☐ Yes

Are you interested in trying contact lenses? ☐ No ☐ Yes

Contact lens wearer, what brand of contact lenses do you wear:_____

How often do you replace your contacts? _____

Have you had an eye exam in the past 2 years? ☐ No ☐ Yes Place of last exam _____

Please list if you have ever had any eye injuries, diseases or surgeries (eg. lazy eye, glaucoma):

_____

Do you experience any of the following:

Blurry vision	☐ No ☐ Yes	Double vision	☐ No ☐ Yes
Red Eyes	☐ No ☐ Yes	Watery eyes	☐ No ☐ Yes
Itchy Eyes	☐ No ☐ Yes	Dry Eyes	☐ No ☐ Yes
Flashing lights	☐ No ☐ Yes	Floaters	☐ No ☐ Yes

Other_____

PERSONAL MEDICAL HISTORY

Do you have any allergies to medication? ☐ No ☐ Yes If yes, please list:

_____

Please list all medications you are currently taking (including over the counter)

_____

Please list any major surgeries you have had:

_____

Do you or have you ever experienced any problems in the following areas?

Neurological (eg. headaches, migraines, seizures)	☐ No ☐ Yes	Describe: _____
Ear/Nose/Throat (eg. allergies, sinus)	☐ No ☐ Yes	Describe: _____
Endocrine (eg. diabetes, thyroid)	☐ No ☐ Yes	Describe: _____
Respiratory (eg. asthma, bronchitis)	☐ No ☐ Yes	Describe: _____
Vascular (eg. high blood pressure, high cholesterol)	☐ No ☐ Yes	Describe: _____

Other:

_____

Are you pregnant or nursing? ☐ No ☐ Yes

FAMILY MEDICAL & EYE HISTORY

Has anyone in the patient's family (blood relative) had any of the following?

Cornea Disease	☐ No ☐ Yes	Crossed Eyes	☐ No ☐ Yes
Glaucoma	☐ No ☐ Yes	Lazy Eye	☐ No ☐ Yes
Macular Degenration	☐ No ☐ Yes	Retina Disease	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	Cancer	☐ No ☐ Yes

Other:

_____

Returning Patients: If there is no change to above information, please sign and date below.

_____Date_____