New Patient Information

Name: ________________________________

Date of Birth: ________________________

Care Card # __________________________

Who is your family doctor? (Location)	
Please list any other doctors or optometrist that care for you:	
What is the main reason for your visit today?	
Have you had refractive surgery (LASIK; PRK) and if so when and by which doctor?	
Do you Drive? O YES O No	
Eye History: Please list any known eye problems (eg. glaucoma, macular degeneration, cataract): ____________________ ____________________ ____________________	Medical History: Please list current or past medical problems (high blood pressure, cancer, diabetes, migraines): ____________________ ____________________ ____________________
List all Medications and eye drops that you take: ____ ____	
Do you have any allergies (please list):	
If you would like to receive email /text appointment confirmations please provide your contact details here and select which you would like us to use: ❑ Email:______________________________ ❑ Phone:______________________________ ❑ Signature: __________________________ By signing here you consent to electronic communication about your appointment time and reminders.	

Patient Information:
Address: ______________________________

Consent for electronic communication (e-communication)

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use e-communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of e-communications:

- Use of e-communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of e-communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep e-communications that pass through their system.
- E-communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- E-communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of e-communications, back-up copies may exist on a computer system.
- E-communications may be disclosed in accordance with a duty to report or a court order.

Conditions of using the Services

- While the Physician will attempt to review and respond in a timely fashion to your e-communication, the Physician cannot guarantee that all e-communications will be reviewed and responded to within any specific period of time. **The Services will not be used for medical emergencies or other time-sensitive matters.**
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and the Physician will not use the Services to communicate sensitive medical information
- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.
- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

I have reviewed and understand all of the risks, conditions, and instructions described above:	
Patient signature:	Date: