NORTHWEST
EYE DOCTORS

Northwest Eye Doctors
#105 - 13737 96 Avenue
Surrey, BC V3V 0C6
Tel: 778-394-6933 / Fax: 778-394-6935
Northwesteyedoctors@gmail.com

Patient Intake Form

Please fill out to the best of your ability prior to the examination. You may email this form to the clinic or bring it with you at the time of your examination.

DATE: _____

Last Name: _____ **First Name:** _____
PHN / MSP #: _____ **Date of Birth** (DD/MM/YYYY): _____
Cell Phone: _____ **Home Phone:** _____
Email Address: _____
Home Address: _____
City: _____ **Province:** _____ **Postal Code:** _____

Extended Health/Insurance Information (if applicable), we can attempt to direct bill:
Primary Policy Provider: _____
Policy Number: _____
Identification Number: _____
Policy Holder Name: _____
Primary Policy Holder DOB: _____

Do you have a second Insurance Policy? ( ) Y ( ) N , if yes please fill below:

Secondary Policy Provider: _____
Policy Number: _____
Identification Number: _____
Policy Holder Name: _____
Primary Policy Holder DOB: _____

Date of Last Exam: _____ **Location:** _____
Family Physician: _____ **Phone:** _____

PLEASE SEE NEXT PAGE TO COMPLETE FORM (1/3)

Occupation:

_____

How did you hear about us:

_____

Reason for Visit:

( ) Recall ( ) New Glasses ( ) New Contacts ( ) Eye Health Concern

( ) Other: _____

_____

Do you currently wear: **Glasses** **Y / N**

Contacts **Y / N** **Type/Brand/Power** _____

_____

Please provide a list of your current medication and health conditions:

_____

_____

_____

_____

Do you have any medical allergies:

_____

Have you had any eye surgeries: ( ) Y ( ) N (please list if yes)

_____

_____

_____

Have you been diagnosed with any of the following:

( ) Diabetes **( ) High Blood Pressure**

( ) Thyroid **( ) COPD**

( ) Glaucoma **( ) Cataracts**

( ) Macular Degeneration **( ) Strabismus/Lazy Eye**

Any other questions or issues you would like the doctor to know or address:

_____

PLEASE SEE NEXT PAGE TO COMPLETE FORM (2/3)

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS TO OPTED OUT PRACTICIONERS
Dr. Satinder Bains # 88814
Dr. Harpinder S. Gill # 88617
Dr. Darshan S. Matharu # 87704

I authorize the Medical Services Plan to pay the above named optometrists directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge that I will be personally responsible for the amount that is reimbursable by Medical Service Plan which will be directed to the above named Optometrists to be applied against my outstanding monies I own for services provided.

Dear Patient:
This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise your of his/her full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

DATE: _____

NAME: _____

Signature: _____

Extended Medical Insurance - Optical

The cost of your eye examination and optical treatments may be covered by an extended medical plan. Optical and health plans can vary greatly. Conditions and percentage of payments are contracted between you, your employer and the insurance company.

Whenever possible, we will determine the percentage of the proposed treatment covered by your plan. Our office will submit a claim on your behalf for direct payment to us, if possible. Your portion of the bill, if any, is to be paid at the time of service.

I authorize Northwest Eye Doctors to submit on my behalf, optical claims to my extended health company. If for any reason, the plan does not pay the requested amount I understand that I am personally responsible for the balance owing.

Signature: _____

Date: _____

COMPLETED (3/3)