Patient History/
Assignment of Medical Services Plan Benefits
To Opted Out Practitioner

Trail Vision Care Clinic
Dr. Nina Pasin, Dr. Lindsay Geeraert, Dr. Nevada Sweeney, Dr. Alf Semenoff

Name (as on care card): _____ Birth Date (m/d/y) __/__/____
e-mail address: _____
When was your last eye exam? _____

Your Medical History:
Changes in past year:
_____
_____
_____

Today's Eye Examination:
Is there anything in particular you'd like to discuss with your optometrist today:
_____
_____

Changes to Medications/Drops:
_____
_____
_____

Do You Need Help With:

Watery Eyes:	Yes__ No__
Burning/Dry Eyes:	Yes__ No__
Red Eyes:	Yes__ No__
Fine Lines, Wrinkles, Age Spots:	Yes__ No__
Rosacea:	Yes__ No__

COMMUNICATION POLICY:

Please sign below, indicating that you accept and give permission to Trail Vision Care to contact you via e-mail and/or text message.

Signature: _____ **Date:** _____

If minor, please print parent/guardian's name: _____

PRIVACY POLICY:

Privacy of personal information is an important principle to Trail Vision Care. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the optometric services and products that we provide. We also try to be open and transparent as to how we handle personal information. This policy is available upon request. Please sign below indicating your acknowledgement and acceptance of this policy.

Signature: _____ **Date:** _____

If minor, please print parent/guardian's name: _____