CALGARY FAMILY EYE DOCTORS

Full Name_____ Birthdate (mm/dd/yy)_____

Guardian Name_____ Relationship (parent, grandparent…)_____

Guardian Phone number_____ Guardian cell_____

Guardian Email_____

Address_____ City_____ Postal Code_____

Emergency Contact Name_____ Number_____ Relationship_____

Alberta Health Care #_____ Family Doctor_____

Grade_____

Reason for visit_____ Last Eye Exam_____

How did you hear about our clinic?_____

Do you wear contacts? ❍No ❍ Yes Type_____

Do you have eye care insurance ❍ No ❍ Yes Provider_____

Family	Self	
❍	❍	Macular Degeneration
❍	❍	Cataracts
❍	❍	Retinal Detachment
❍	❍	Glaucoma
❍	❍	Colour Blindness
❍	❍	Eye Surgery
❍	❍	Dry Eye
❍	❍	Crossed Eye/Lazy Eye
❍	❍	Diabetes

Self	
❍	High Blood Pressure
❍	Heart Problems
❍	High Cholesterol
❍	Cancer
❍	Thyroid Condition
❍	Asthma
❍	Arthritis
❍	Stroke
❍	Other

Medications_____

Allergies_____

Electronic Communication Authorization and Consent to contact guardian on behalf of patient
(For appointment reminders, clinic events and specials only –unsubscribe at any time)

I consent to Calgary Family Eye Doctors and their affiliates sending me information about Calgary Family Eye Doctors and their products and services by e-mail and other electronic communication. **I understand I can withdraw my consent at any time** by contacting B. Hopfauf & Heather Cowie Professional Corporation at Suite 1125-10655 Southport Road SW, Calgary, AB T2W 4Y1 | 403-225-5660

Date_____ **Signature**_____