MINOR

CALGARY FAMILY EYE DOCTORS

Full Name_____Preferred Name _____

Birthdate (mm/dd/yy)_____ Alberta Health Care # _____

Guardian Name_____Relationship (parent, grandparent…)_____

☎Guardian Phone Number_____☎Guardian Cell_____

Guardian Email_____

Address_____City_____Postal Code_____

Emergency Contact Name_____☎ Number_____Relationship_____

Grade (if applicable) _____

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_____

Member ID _____

Policy/Group #_____

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

Family	Self	
		High Blood Pressure
		Heart Problems
		High Cholesterol
		Cancer
		Thyroid Condition
		Asthma
		Arthritis
		Stroke
		Diabetes

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**_____