CALGARY FAMILY EYE DOCTORS

Legal Full Name: _____ Preferred Name: _____

Birthdate (mm/dd/yyyy): _____ Alberta Health Care #: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

☎Home Phone: _____ ☎Cell Phone: _____Email: _____

Reason for visit: _____ Last eye exam date: _____

How did you hear about our clinic?: _____

Do you wear contact lenses?: Yes No Type: _____

Do you have eye care insurance?: Yes No Provider:_____

Or give insurance card to the front desk 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: _____

Do you smoke? Yes No

Electronic Communication Authorization and Consent (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**_____

Insurance Submission Authorization and Consent

I agree to the collection and disclosure of my personal information, and if applicable, my spouse and/or dependant's personal information so that Calgary Family Eye Doctors may submit claims on my behalf. I hereby assign benefits payable for the eligible claims to Calgary Family Eye Doctors and I authorize the insurer/plan administrator to issue payment directly to Calgary Family Eye Doctors. In the event that my claims(s) are declined by the insurer, I understand that I remain responsible for payment to Calgary Family Eye Doctors for any services rendered and/or supplies provided. If I am a spouse or dependant, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to Calgary Family Eye Doctors.

Date_____ **Signature**_____