Airdrie Family Eye Doctors

Full name _____ Birth date (mm/dd/yy) _____

Address _____ City _____ Postal code _____

Home phone _____ Cell _____ Email _____

Preferred method of contact: ☐ Phone call (circle: Home / Cell) ☐ Text ☐ Email

Emergency contact _____ Phone _____ Relationship _____

Alberta Health Care # _____ Family doctor _____

Specialist doctors _____

Do you have health insurance? ☐ Yes ☐ No Provider _____

How did you hear about our clinic? _____

Reason for visit _____ Last eye exam _____

Do you wear contacts? ☐ Yes ☐ No Type _____

Are you interested in contacts? ☐ Yes ☐ No

Interested in refractive surgery? ☐ Yes ☐ No

Allergies _____

Medications _____

Do you smoke? ☐ Yes ☐ No

Occupation _____ Hobbies _____

Hours of digital device use/day: _____

Family	Self	
☐	☐	Macular degeneration
☐	☐	Cataracts
☐	☐	Retinal detachment
☐	☐	Glaucoma
☐	☐	Colour blindness
☐	☐	Eye surgery
☐	☐	Dry eye
☐	☐	Crossed/Lazy eye
☐	☐	Diabetes

Self	
☐	High blood pressure
☐	Heart problems
☐	High cholesterol
☐	Cancer
☐	Thyroid condition
☐	Arthritis
☐	Stroke
☐	Other:

Electronic Communication Authorization and Consent (for appointment reminders, clinic events, and specials only -unsubscribe at any time)
I consent to Airdrie Family Eye Doctors (AFED) and their affiliates sending me information about AFED 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 & H. Cowie Professional Corporation at Suite 600-705 Main Street, Airdrie, AB, T4B 3M2.

Date _____ **Signature** _____

Insurance Submission Authorization and Consent (including private insurance and Alberta Health Care)
I agree to the collection and disclosure of my personal information, and if applicable, my spouse and/or dependant/personal information so that Airdrie Family Eye Doctors (AFED) may submit claims on my behalf. I hereby assign benefits payable for the eligible claims to AFED and I authorize the insurer/plan administrator to issue payment direction to AFED. **In the event that my claim(s) are declined by the insurer, I understand that I remain responsible for payment to AFED for any services rendered and/or supplies provided.** If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to AFED.

Date _____ **Signature** _____