Cloudbreak EYE CARE

Southern Alberta Eye Center
Suite 315 – 5340 1st Street SW
Calgary, AB T2H 0C8

+1.403.281.0603
+1.403.281.2471
info@cloudbreak.ca
www.cloudbreak.ca

GLAUCOMA | ADVANCED ANTERIOR SEGMENT | COMPREHENSIVE | CATARACT

Name _____ _____ _____
LAST FIRST MIDDLE

(Legal name as it appears on Alberta Healthcare Card)

Gender: Male Female **Date of Birth:** Day _____ Month _____ Year _____

Healthcare # _____ **Province** _____

Please ensure your healthcare # is valid. Patients with invalid or no coverage will be responsible for payment of services

Private Insurance (Provider Name) _____ **WCB Claim? Yes / No**

Home Address _____

City _____ **Province** _____ **Postal Code** _____

Cell Phone ( ) _____ - _____ **Alternate Phone** ( ) _____ - _____

Email _____ **Occupation** _____

Emergency Contact _____ **Relationship** _____

Cell Phone ( ) _____ - _____

Referring Doctor _____ **Family Doctor** _____

Medical Conditions:

NONE ☐ DIABETES ☐ HIGH CHOLESTEROL ☐

BLOOD PRESSURE ☐ LUNG DISEASE ☐ HEART DISEASE ☐

OTHER: _____

Current Medications: _____

NONE ☐

_____

Drug/Latex Allergies: _____

NONE ☐

PLEASE COMPLETE BOTH SIDES OF THIS PAGE

MISSED APPOINTMENTS WILL BE SUBJECT TO A 'NO-SHOW' FEE

WE KINDLY ASK FOR 48 HOUR NOTICE IF YOU ARE UNABLE TO ATTEND A SCHEDULE APPOINTMENT

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Research Consent:
Cloudbreak Eye Care values research as an avenue toward improving vision care. This research cannot succeed without the support of our patients in allowing us to review and/or use their clinical results as a way to further the knowledge and advancement of ophthalmology research. Do you consent to allow Cloudbreak Eye Care use of your medical records in research projects? No personally identifying information will be released or published in this process.

☐ **YES, I consent** ☐ **NO, I do not consent**

Release of information to other Health Professionals:
Sometimes the assistance of other health care professionals is beneficial to ensure the highest and most complete level of patient care in a diagnosis and/or treatment. Do you consent to allow Cloudbreak Eye Care to release your medical information to other health care professionals sharing in your care and as they deem necessary to provide the most appropriate care for your ophthalmology and medical health needs?

☐ **YES, I consent** ☐ **NO, I do not consent**

Release of information to Cloudbreak Eye Care:
Do you consent to allow other health care professionals to release your personal health information to Cloudbreak Eye Care at the request of your physician as he/she deems necessary to provide the most appropriate care for your ophthalmology and medical health needs?

☐ **YES, I consent** ☐ **NO, I do not consent**

Date: ____ /____ / 20____
DD / MM / YYYY

Patient Signature: _____
(or legal representative, if applicable or if patient is under 18 years of age)

Witness Signature: _____
Receptionist

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