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 _____ _____ _____
FIRST MIDDLE LAST
(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 PHN 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** ( ) _____ - _____

A mobile phone # is needed to receive appointment reminders via text message

Email _____ **Occupation** _____

Name of Emergency Contact _____ **Relationship** _____

Primary 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

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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**

Appointment Reminders:
Do you consent to receive appointment reminders via text message including appointment date and time? *Please note that this is an automated service to assist patients and does not replace personal responsibility to record and attend scheduled appointments.*

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

Appointment Policies and Reminders:
Please allow yourself 1-3 hours for each appointment
Please provide at least 48 hours notice if you are unable to attend a scheduled appointment
Missed appointments or late cancellations will be subject to a 'No-Show' fee

☐ **YES, I have read and understand these policies**

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

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