

Please answer all questions and sign the front and back pages

Patient Legal Name: _____
(Last) (First) (Middle)

Sex: Male / Female Date of Birth: day _____ month _____ year _____

Health Care #: _____ Province: _____

Is this a Workers Compensation Claim (WCB)?: yes no

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Work Phone: () _____ - _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

Relationship: _____ **Phone # (different than above):** _____

Referring Doctor (first and last name & Location)/or N/A: _____

Family Doctor (first and last name & Location)/or N/A: _____

Optometrist (first and last name & Location)/or N/A: _____

Current Medical Conditions and Medications (circle all conditions that apply)

- | | | | |
|----------------------|------------------------------|----------------|----------------------------|
| High Blood Pressure | Diabetes Type 1 Type 2 | Kidney Disease | Rheumatoid Arthritis |
| High Cholesterol | Cancer (type) | Lung Disease | Osteoarthritis |
| Heart Disease | Thyroid Disease | Asthma COPD | Smoking: (circle one) |
| Pentosan Polysulfate | Elmiron | Plaquenil | Never Current Former |

Prior Medical History (circle all that apply)

- | | | | |
|---------------|---------------------|---------------|-----------------------|
| Stroke (year) | Heart Attack (year) | Cancer (type) | Kidney Failure (year) |
|---------------|---------------------|---------------|-----------------------|

Other Medical Conditions (please list or NONE) _____

Medications and Supplements (please list all or provide list or NONE) _____

Surgical History (please list ALL SURGERIES or NONE) _____

Allergies (please list or NONE) _____

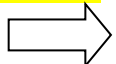
I verify that the above information is true and accurate to the best of my knowledge:

Signature: _____
(patient or legal representative, if applicable or if patient is under 18)

Printed name: _____

Date: _____

CONTINUED ON PAGE 2 – please turnover



Please be aware that your picture will be taken for identification purposes, it will be kept strictly confidential in your chart.

Calgary Retina Consultants (CRC) are strongly committed to clinical vision research to further advance knowledge and treatment of eye disease in their patients. One method of research is to review patients' medical records by ophthalmologists and associated staff in order to:

- identify patients who might be eligible to participate in a given study approved by a research ethics committee (prospective studies) and
- identify patients and document findings for answering a given research question (retrospective studies).

Results from prospective and retrospective studies could be presented at research conferences and/or published in scientific medical journals with assurance that no personal identities (name, address, date of birth, Alberta Health Care number) will be disclosed.

To achieve this, we need your authorization to review your medical records:
Please complete the following section.

I, _____, (print your name)

authorize refuse (check one) the CRC Physicians, their designates, and staff to review my medical records for prospective and retrospective studies. This consent is valid for the duration of my care as a patient at this practice unless I revoke my consent.

Sign: _____

Date: _____

Authorization to access your Alberta Netcare record, as needed:

Sign: _____

Date: _____

Authorization to release/receive your medical information to/from another physician for continuity of patient care:

Authorize Refuse (check one)

Sign: _____

Date: _____

Revised JUNE 2022