PATIENT INFORMATION

Personal Details - The demographic details listed below include methods that we may contact you by. Are your details correct? Please check and edit where necessary.

Name:_____ **DOB:**:_____/_____/_____

Address :_____

_____

Phone:_____ **Other phone:**_____

Do you consent to the use of SMS Reminders for appointments: YES NO (Please circle)

Email address (personal):_____

Next of Kin : Name : ._____ Telephone : _____

How did you hear about us? (please circle) Family Friend Doctor Optometrist Website

Other? (please note)_____

MEDICARE AND/OR CONCESSION CARD DETAILS

Medicare number :_____

Number next to your name :_____ (single digit)

Expiry date :_____

Veterans Affairs number :_____

Expiry date :_____

Pension Card Number :_____

Expiry date :_____

Healthcare Card Number :_____

Expiry date : _____

Commonwealth Seniors Card Number:_____

Expiry date : _____

Private Health Insurance

Health Fund Name :_____

Full Hospital Cover	YES	NO
Ancillary cover	YES	NO

Membership Number:_____

Parent/Guardian (IF REQUIRED)

First Name:_____ **Surname**:_____

DOB::_____/_____/_____ **Relation to patient:**_____

Medicare number : _____

Number next to your name :_____**(single digit)**

Expiry date :_____

Your General Practitioner Name :_____

Practice Address :_____

Who recommended our practice to you:_____

Previous Ophthalmologists seen:_____

Practice Address:_____

_____

PLEASE READ AND SIGN

I provide consent for Dr Colley/ Dr Khan / Dr Richards/ Dr Ng to collect, use and disclose my personal information as described by the principles of the Privacy Act 1988.

I understand that de-identified information about me (including eye images, and test results) may form part of professional educational, audit, or research activities. This information is securely stored within our practice in accordance with our privacy policy. Identifiable information about me, however, will not be disclosed publicly without further consent.

Additionally, I consent to the use of routine diagnostic medications, (i.e. eye drops), and routine diagnostic tests (intraocular pressure and corneal thickness), for the purposes of assessment and diagnosis.

A current doctor's or optometrist's referral is required for my full Medicare reimbursement; I understand that it is my responsibility to keep my referral up to date. I acknowledge that unpaid accounts requiring the services of a debt collector will incur an additional charge.

Signature : ..... Date :.....

PLEASE ENSURE YOU COMPLETE THE NEXT PAGE
THIS IS IMPORTANT INFORMATION RELATING TO ANY PREVIOUS MEDICAL CONDITIONS AND ANY CURRENT MEDICATION

PLEASE LIST YOUR MEDICATIONS AND ALLERGIES

Your allergies to any medications

Medication: What happens if you take this medication?

Other allergies:

List any medication you are currently taking:

Name of medicines: AND, why do you take these medicines?

List any current and /or previous illness or medical problems:

List your previous operations/admissions to hospital: