Eye Surgery Associates

OPHTHALMIC SURGEONS

PATIENT REGISTRATION FORM

PERSONAL DETAILS:	Title: Dr / Mr / Mrs / Ms / _____		
Surname:		First Name:	
Known Name:	Date of Birth:	Occupation:	
Address:		Suburb:	
Post Code:	Email:		
Telephone: Mobile:	Work:	Home:	
Medicare Number: _____/_____/_____	Patient No: 1 2 3 4 5 6 7	Expiry Date:_____/_____	
Are you of Aboriginal and/or Torres Strait Islander origin? Yes / No / Non Identified			
Pension/ Health Care Card Number:		Expiry Date:_____/_____/_____	
Private Insurance Health Fund:		Membership No:	
Veteran's Affairs VX Number:			
TAC:	Date of Accident:	Claim No:	
WorkCover Insurance Co:			
Claim Manager:	Claim No:		
Other:	Name:	Telephone:	
Address:			
Next of Kin:	Relationship:	Telephone:	
May we use SMS to communicate with you regarding your appointment? Yes / No If 'No', do you have a carer or relative that we can SMS your next appointment time? Yes / No Carer / Relative's Name: Mobile Number: May we use email to communicate with you regarding your appointment? Yes / No			

G.P. Name:		Optometrist Name:	
Clinic Name:		Clinic Name:	
Address:		Address:	
	Telephone:		Telephone:
Do you have any other medical specialists involved with your care? (e.g.: cardiologist, endocrinologist etc.)			
Name:		Name:	
Address:		Address:	
	Telephone:		Telephone:
Do you consent to a report on your condition being sent to all medical providers above? Yes / No			

Failure to Attend / Cancellation within 24 hours of Appointment Fee: Standard consultation fees may apply for cancellations and changes within 24 hours of scheduled appointments, and for failing to attend your appointment.

Continue over page.

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PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- **A valid referral.**
- Your current glasses.
- A list of all information about your medical history, any significant health problems or previous operations.
- A list of all current medications, including eye drops, injections or tablets.
- A list of all allergies to all medications.
- Details of relevant family history.

* Please allow 90 - 120 minutes for your appointment. Extra time may be required if further diagnostic tests or minor procedures are performed on the day.

* We recommend you have a driver / carer with you as your vision may be blurred from dilating eye drops.

FEES: Full payment is required on the day of consultation.

	Private	Pensioner
Initial Consultation	$235	$190
Initial Consult (Complex/Second Opinion)	$305	$305
Initial Consultation (Child)	$275	-
Review Consultation	$120	$100
Review Consultation (Major)	$195	$155
Bilateral A-Scan	$300	$225
Bilateral Visual Fields	$235	$180
Bilateral OCT (Ocular Coherence Tomography)	$175	$135
Bilateral CVK (Computerised Videokeratography)	$250	$190

All fees are applied at the discretion of the treating Ophthalmologist.

Diagnostic Tests and Minor Procedures: These may be required by your ophthalmologist on the day and offer immediate treatment and management of your condition. Additional fees are charged for these tests and procedures. Some of these fees are not claimable from Medicare. We will endeavour to inform you of these fees on the day. Please ask our staff if you would like more information on these costs at the time they are being performed. In the unlikely event that your account is referred to a debt collection agency or solicitor, you agree to pay the additional fees incurred in the collection of the debt.

Surgery Quotes: We will provide a full estimation of costs and details for all surgery bookings.

PRIVACY STATEMENT: We endeavour to provide you with optimal medical care. This requires us to collect your personal and health information. At times this information may be required to be shared across an extended medical team. Your information will also be used for administrative and billing purposes, and may be shared with other agencies, such as Medicare and private health funds, as required. Your health information may be used for such secondary purposes as research, trials and audits. No information that personally identifies you will be disclosed for these purposes. For further information regarding our Privacy Policy please see our website www.eyesurgery.com.au.

I (*print name*) _____ have read and understood the above information; fully consent to the sharing of my health information; and agree to the payment terms.
Signed: _____ Date: _____/_____/____
If Guardian, please state relationship to the patient: _____