Eye Surgery Associates

OPHTHALMIC SURGEONS

# PATIENT REGISTRATION FORM

| **PERSONAL DETAILS:** | Title: Dr / Mr / Mrs / Miss / Ms _____ *(Please specify)* | Gender: M / F / I / U |
|---|---|---|
| Surname: | First Name: | |
| Known Name: | Date of Birth: ___ / ____ / ______ | Occupation: |
| Address:<br><br>Suburb: | Post Code: | State: |
| Email: | | |
| May we use email to communicate with you? Yes / No | | |
| Mobile # | Work # | Home # |
| May we use SMS to communicate with you? Yes / No<br>If 'No', do you have a carer or relative that we can communicate with via SMS on your behalf? Yes / No<br>Carer / Relative's Name: | Mobile # | |
| Medicare Number: __ __ __ __ __ / __ __ __ __ __ / __ | Patient No: __ | Valid To: ____ / ______ |
| 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: | Expiry Date: ____ / ____ / ______ | |
| TAC / WorkCover (Insurer Name): | | Date of Accident: |
| Claim No: | Claim Manager: | Telephone: |
| Next of Kin: | Relationship: | Telephone: |
| May your Next of Kin make enquiries and receive communications regarding your personal & medical history and care? 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: |

If you are **non-weight bearing** or have **mobility restrictions**, please contact us prior to your appointment to discuss.

***Continue over page…***

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## PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT

- **A valid referral** is required to claim a Medicare subsidy**.**
- 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.
- Sunglasses to wear when leaving the clinic.

Please arrive 15 minutes prior to your appointment to complete your registration. 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** We are a private clinic. Full payment is required on the day of consultation.

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: If surgery is required, we will provide a full estimation of costs and details for all surgery bookings.

## 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 or for failing to attend your appointment.

## PRIVACY STATEMENT

We endeavour to provide you with optimal medical care. This requires us to collect your personal and health information. It important that we are able to share this information with other clinicians involved in your care. Your information will also be used for verification and identification purposes; administrative and billing purposes; and may be shared with other agencies. These agencies may include Medicare and private health funds required to facilitate claims. Your health information may also be used for research and audit purposes.

Our Privacy Policy contains more information about our privacy practices, including how: we use your information; you may request access to your records; you may correct your personal information; you can lodge a privacy complaint and how we manage such complaints. You can obtain a copy of the latest version of our privacy policy by contacting us or visiting www.eyesurgery.com.au/privacy-policy/

I (*print name*) ______________________________ have read and understood the above information regarding the privacy statement and the fees, and agree to the payment terms.

Signed ______________________________ Date ______________

If Guardian, please state relationship to the patient: ______________________________