# PATIENT REGISTRATION FORM

**Personal Details:** Dr ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Mstr ☐

Surname: ……. First Name: ……

Preferred Name: ……... Date of Birth: ……. / ……. / ……

Address: ……

…… Postcode: ……

**CONTACT:** Home: …… Work: ……

Mobile: …….. Email: ……...

**Please tick if you DO NOT WANT to be contacted via SMS for appointment reminders** ☐

**Next of Kin:** (usually a partner, relative or close friend):

Name: ……..…… Relationship: ……

**CONTACT:** Home: ……..…… Mobile: ……...

**Regular General Practitioner:**

Name: …….. Clinic ……..……

Address ……..……...

**Regular Optometrist:**

Name: ……..…….. Clinic ……

Address ……..……...

**Medicare:** YES ☐ NO ☐

Card No: ……..…. Ref No (next to your name): ……. Expiry: ……...

**Pension or Concession Card:** YES ☐ NO ☐

Card No: ……..…….. Expiry: ……

**Department of Veterans Affairs Details:** YES ☐ NO ☐

DVA No: …… Expiry Date: ……..……..... Gold Card: ☐

**Private Health Insurance Details:** YES ☐ NO ☐

Name of Fund: ……..…… Member No: ……...

Ref No (next to your name): …… Hospital Cover: YES ☐ NO ☐

**Fees:** **This is not a bulk billing practice. Payment is required in full on the day of consultation. We do not accept American Express or Diners. Our fees to do not exceed the AMA recommended fee.**

| | | | |
|---|---|---|---|
| First consultation | $ 190.00 | Medicare rebate | $ 75.05 |
| Further consultations | $ 105.00 | Medicare rebate | $ 37.70 |
| Paediatric consultation | $ 250.00 | Medicare rebate | $ 169.05 |

***Pension / Concession Card Holders:***

| | | | |
|---|---|---|---|
| First consultation | $ 160.00 | Medicare rebate | $ 75.05 |
| Further consultations | $ 90.00 | Medicare rebate | $ 37.70 |

***FEES NOT APPLICABLE FOR DVA GOLD CARD HOLDERS***

*NB: Additional charges may be payable if your ophthalmologist requires other testing to be undertaken.*

***PLEASE TURN OVER***

# PRIVACY LEGISLATION CONSENT FORM

In accordance with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012 and the Australian Privacy Principles.

We require your consent to collect personal details about you. Please read this information carefully and sign where indicated below.

In order to provide you with the highest standard of eye care, this practice is required to collect personal information from you. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be pro-active in your health care needs.

We value the need to safeguard this information and would like to assure you that the information you provide will only be used in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your direct health care, including doctors and allied health providers outside this medical practice. This may occur through referral to other doctors, allied health providers, or for medical tests and in the reports or results returned to use following the referrals.

- I have read the above information and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment I receive.
- I am aware of my right to access the information collected about me, and it will be provided to me in accordance with the Federal Privacy Act 2001.
- I understand that if my information is to be used for any other purpose other than those detailed above, my further consent will be obtained.
- I acknowledge that I have read and agree to the fee structure of the practice.
- I consent to the use of the facsimile machine for sending and receiving my information as required.

Please sign this form as confirmation that you have read and understood our privacy policy and consent to the use of your health information as above.

*Patient / Guardian / P.O.A Name:* _____

*Signature:* _____ *Date:* _____/_____/_____