SOUTH EASTERN EYE SURGERY saving sight since 1994

NEW PATIENT REGISTRATION FORM

Mr ○ Mrs ○ Ms ○ Miss ○ Master ○ Dr ○

First Name: ___________________________ Last Name: _____________________________

Date of Birth: _____/ _____/ ____________ Medicare No: ___________________________

Medicare Card Expiry: _____/ _____/______ Medicare Prefix No: before name: ________

Address: ____VIC Post Code: _______

Mobile Ph.No: _________________________ Home Ph. No: __________________________

Pension/Veteran's/Health Care Card No: __________________ Expiry: ____/____/______

Private Health Insurance (for Hospital Cover Only)

Name of the Private Health Fund: ____

Member No: ____Expiry: ____/____/______

IN CASE OF AN EMERGENCY - CONTACT PERSON'S DETAILS:

First Name: ____________________________ Last Name: ____________________________

Relationship to you: ____________________ Mobile or Tel.No:______________________

FOR CHILDREN UNDER 18 - PARENT'S (ACCOUNT PAYER) DETAILS

Parent First Name: ____________________ Parent Last Name: _____________________

Parent Date of Birth: ____/ ____/ _______ Parent Medicare No: ___________________

Parent Medicare Card Expiry: ____/ ______ Medicare Prefix No: before name: _______

81 Ann Street, Dandenong, VIC 3175
460 Boronia Road, Wantirna South , VIC 3152
Email:admin@seeyesurgery.com.au

Tel: (03) 9792 2156
Fax:(03) 9706 9882
Web: www.seeyesurgery.com.au

NEW PATIENT REGISTRATION FORM

Your Optometrist's Details (If Applicable)

Optometrist's Name: ____

Optometrist's Practice Name: ______________________________________

Optometrist's Address: ____________________________VIC Post Code: _______

Your GP's Details

GP's Name: ____

GP's Practice Name: ____

GP's Address: __________________________________ VIC Post Code: _______

Details of Other Doctors involved in your Primary Care:

Dr's Name: ____

Dr's Practice Name: ____

Dr's Address: __________________________________ VIC Post Code: _______

How did you hear about us?

Google Search ○

Recommended by Family & Friends ○

Recommended by my GP ○

Recommended by my Optometrist ○

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HEALTH QUESTIONNAIRE

Date: _____/ ____/ _______

Do you have any Medical Conditions like?

Asthma ○ High Cholesterol ○ High Blood Pressure (BP) ○

Diabetes ○ Heart Disease ○

Please list the Medications you are currently taking:

1) ____

2) ____

3) ____

4) ____

5) ____

Please list any Allergies you have:

1) ____

2) ____

3) ____

Do you have a Family History of the following Eye Conditions?

Glaucoma ○ Diabetes ○ Macular Degeneration ○ Other ○ Nil ○

Do you have a past history of Eye Surgery or LASER? Yes ○ No ○

NON ATTENDANCE POLICY

South Eastern Eye Surgery provides an SMS appointment reminder and confirmation service 2 days before your appointment. Alternatively, we call the landline to confirm your attendance.(Whilst there are emergencies and illness that can occur on the day of your appointment and we are sympathetic to these one-off occasions). I understand that I will provide at least 24 hours' notice if I wish to cancel my appointment. Yes ○

PAYMENT POLICY

I agree to the clinic's terms of payment and accept that payment is required on the day of all consultations along with any procedures or scans that may be performed. Yes ○

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PRIVACY POLICY

We at South Eastern Eye Surgery, are required to record your consent to collect personal information about you. Please read this information carefully and sign where indicated below. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly manage your health care needs. This means we will use the information you provide in the following ways:

- Administrative and informative purposes in running the practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosures to others involved in your health care, including your referring doctor, optometrist and specialists outside this practice. This may occur through reports we send back to your doctor or optometrist; or through letters of referral to other doctors or healthcare providers via email, post or fax.

I have read the information above 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 by me, but my failure to do so might compromise the quality of healthcare and treatment given to me.

I am aware of my right to access the information collected from me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is used for any other purpose other than set out above, my further consent will be obtained.
I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice in writing. **I accept the above privacy policy. Yes ○ No ○**

Date : _____/ _____/_______

Signed by Patient/ Parent: ________________________________

Printed Name: ________________________________