Terrace Eye Centre

NEW PATIENT– PRIVATE & CONFIDENTIAL

Patient Details

Title _____ Surname _____ Given Names _____

Preferred Name _____

Date of Birth _____ Gender Male ☐ Female ☐

Address _____ Postcode _____

Postal Address _____

Telephone (H) _____ (M)_____ (W) _____

Email _____

GP Details: _____ Location _____

Next of Kin _____ Contact No. _____

Health Fund Details

Medicare Number _____ Ref No. _____ Expiry Date _____

Dept. of Vet Affairs _____ Expiry Date _____

Pension Card No. _____ Expiry Date _____

Concession Card No._____ Expiry Date _____

Private Health Fund _____ Hospital cover Y / N

Member No._____ Are you serving a waiting period Y / N

Work Cover Claim No. _____ Lodged Y / N

Defence PM Keys No._____

Privacy Statement

In providing you with the best possible health care we need to collect and use your personal information for administrative and billing purpose. This may be used for disclosure to others involved in your health care, including other practitioners outside of Terrace Eye Centre, for research and quality assurance, and in emergency situations for treatment purposes. We must comply with laws relating to the collection and use of your personal information, and a full policy is available on request.

Please tick acceptable methods of communication:

Mobile/SMS ☐ Home Phone ☐ Email ☐ Mail ☐

Family member with whom the doctor can speak to regarding your condition:

_____

Copy Reports to Medical Practitioners:

Name:_____ Location _____

Name:_____ Location _____

Finance Authority (if not patient or patient is a child)

Title _____ Surname _____ Given Names _____

Relationship to Patient _____ DOB _____

Medicare Number _____ Ref No. _____ Expiry Date _____

Address (if different to above) _____

Telephone (H) _____ (W) _____ (M) _____

Consent

I accept responsibility for any associated fees as a result of seeing a doctor at Terrace Eye Centre and it is my responsibility to pay all accounts if my health fund declines payment. I have been informed of the fees for the consultation and any scans. I understand that all accounts are my responsibility. To the extent permitted by law, you agree to pay any expenses incurred by The Terrace Eye Centre in collecting any outstanding accounts due. I understand the reasons why my information must be collected and am aware Terrace Eye Centre has a privacy policy on handling patient information and a copy is available upon request. I understand that I am not obliged to provide my consent to the Terrace Eye Centre handling my information for the purposes set out above.

Signature _____ **Date** _____