

## PATIENT – PRIVATE & CONFIDENTIAL

### PATIENT DETAILS

Title \_\_\_\_\_ Surname \_\_\_\_\_ Given Names: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Post Code \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

GP Details: \_\_\_\_\_ Location: \_\_\_\_\_

Copy to other Medical Practitioners or Optometrists:

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Are you Aboriginal or Torres Strait Islander Origin? Yes  No

Do any Guardianship Orders apply? Yes  No

If patient is a child are there any Parenting Orders in place? Yes  No

### MEDICAL CARD DETAILS

Medicare Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ref No. (beside your name): \_\_\_\_ Expiry Date: \_\_\_\_\_

Dept. Of Vet Affairs: \_\_\_\_\_ (Present Card) Expiry Date: \_\_\_\_\_

Pension Card No.: \_\_\_\_\_ (Present Card) Expiry Date: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_ Hospital Cover: Yes/No Basic  Bronze  Silver  Gold

Member No.: \_\_\_\_\_ Are you serving a waiting period : Yes / No

Work Cover Claim No.: \_\_\_\_\_ Lodged: Yes / No 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:*

\_\_\_\_\_

## FINANCE AUTHORITY (PERSON RESPONSIBLE FOR ACCOUNT IF NOT PATIENT)

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ref No. (beside your name): \_\_\_\_ Expiry Date: \_\_\_\_\_

Address (if Different from above): \_\_\_\_\_

Telephone (if Different from above): (H) \_\_\_\_\_ (M) \_\_\_\_\_ (W) \_\_\_\_\_

## 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, any scans/tests and pathology/radiology. 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.

I Consent to the use of e-mail communications and I am aware of the privacy risks of use of unencrypted e-mail communications.

Signature \_\_\_\_\_ Date \_\_\_\_\_