Terrace Eye Centre

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:_____

GP Details:_____ Location: _____

Copy to other Medical Practitioners or Optometrists:

Name:_____ Location:_____

Name:_____ Location:_____

Next of Kin:_____ Contact Number: _____

Occupation: _____

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) Gold ☐ White ☐ Expiry Date:_____

Pension Card No.: _____ (Present Card) Expiry Date:_____

Private Health Fund: _____ Hospital Cover: Yes/No

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, education and quality assurance, and in emergency situations for treatment purposes. Disclosure may be required for maintenance to our external IT Providers. 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.

Email: _____

Signature _____ Date _____