Patient Registration Form

(Please complete in Black Pen Only)

ROCKHAMPTON EYE CLINIC

By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.
I certify that I have read or had read to me the Initial Appointment Brochure provided by Rockhampton Eye Clinic and understand the costs & procedures involved and agree to proceed with initial and subsequent consultations. I also understand that all tests and measurements are non-refundable. I understand that this practice is NOT a Bulk Billing Practice and I am responsible for full payment for all services rendered on the day of my appointment and that if I am an Inpatient at the Mater Hospital I am responsible for full payment of all services rendered on the day of my appointment. I also understand that if a third party (eg. Rockhampton Hospital, Work cover) is covering the cost of my consultation and they refuse to pay that I will be responsible for the full cost of all services rendered on the day of my appointment.
I authorise this practice to release any of my personal/medical information (released via fax, post, email, medical-objects & Oculo) including the diagnosis, and the records of any treatment or examination to any required professionals or institutions including my GP and Optometrist as seen fit by my treating specialist. A copy of REC's patient privacy policy is available to be viewed at the reception desk on request. I understand that a new referral is required every 12 months (3 months for referrals from specialists). It is my responsibility to ensure that my current referral will be valid for my appointment. If your referral is expired, the Dr's at Rockhampton Eye Clinic will not be able to see you until a valid referral is provided.

_____ _____

SIGNATURE: **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

Next of Kin/Emergency Contact:

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

GP Name: _____Location:_____

Optometrist Name: _____Location:_____

Insurance Information:

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

Department of Veterans Affairs (GOLD CARD ONLY):

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD

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Please write below in your own words, what you think is wrong with your eyes and why you have been referred to the Rockhampton Eye clinic:_____
_____
_____

Have you had any previous Eye Surgery including Refractive Surgery (LASIK): _____

Please list any eye medication that you are currently using: _____

Please list any other medications that you are currently taking: _____

_____

Relevant Medical Conditions (Please tick the correct columns below):-

	NO	YES	
Blood Thinner			
High Blood Pressure			
Diabetes Do you know your sugar levels?			Type 1 ☐ or Type 2 ☐ HBA1C Levels (6 monthly)_____
Uncontrolled Asthma / COPD			
Hepatitis C, Hepatitis B, HIV or any other infectious disease			If yes, which one? _____
Smokers Status			If yes, how many cigarettes per day _____
Are there any other medical conditions that you would like to mention: eg Thyroid, Rheumatoid Arthritis, Heart, Renal, Epilepsy, Cognitive, Sleep Apnoea			
ALLERGIES:			Please List:

IF YOUR APPOINTMENT IS FOR CATARACTS, YOU MUST USE LUBRICATING EYE DROPS 4 TIMES A DAY FOR 1 WEEK PRIOR TO YOUR APPOINTMENT. WE RECOMMEND SYSTANE OR OPTIVE, HOWEVER ANY LUBRICATING DROPS CAN BE USED. THESE CAN BE PURCHASED OVER THE COUNTER AT ANY PHARMACY.

IF YOU WEAR CONTACT LENSES, YOU MUST REMOVE YOUR CONTACT LENSES PRIOR TO YOUR APPOINTMENT.

HARD CONTACT LENSES – REMOVE 1 MONTH PRIOR

SOFT CONTACT LENSES – REMOVE 2 WEEKS PRIOR

PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO THE ROCKHAMPTON EYE CLINIC ON (07) 4931 3573.