Eyes First
Eye Specialist Clinic

# NEW PATIENT REGISTRATION FORM

## PATIENT DETAILS

DOB: ...../...../..... ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr
Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

Surname: ..... First Name: .....

Residential Address: .....

Suburb: ..... Postcode: .....

Mobile ☏: ..... Home ☏: .....

Email Address: .....

Emergency Contact Person: .....

Mobile ☏: ..... Relationship To Patient: .....

**Ethnicity:** ☐ Australian ☐ First Nations ☐ Other .....

MEDICARE: ..... Ref No (next to name): ..... Card Expiry ...../.....

PENSIONER or Health Care Card: ..... Card Expiry : ...../...../.....

DVA CARD: .....

Private Health Insurance: ..... Membership Number: .....

Workcare/TAC Claim No: .....

**PLEASE NOTE: the patient will be responsible for all accounts
until Workcover/TAC Claim No & Insurance Company details are supplied

If the patient is a child or under 18 years old, to whom should the account be addressed to:

Full Name: ..... DOB: ...../...../..... Your Ref on Medicare: .....

## General Practitioner Doctor

Usual GP/Doctor Name: .....

Address: .....

Suburb: ..... Postcode: .....

Phone ☏: ..... Send correspondence letter to GP ☐

## CURRENT AND PAST MEDICAL INFORMATION

**ALLERGIES:** ☐ Nil known ☐ If KNOWN please list below:

| ALLERGY | REACTION | SEVERITY |
|---|---|---|
| | | |
| | | |
| | | |

**MEDICATIONS:** Please list current medications and vitamin supplements below:

| NAME OF MEDICATIONS | DOSE |
|---|---|
| | |
| | |

| NAME OF VITAMINS | DOSE |
|---|---|
| | |
| | |

**MEDICAL / SURGICAL HISTORY**: Please tick all relevant history below:

☐ Heart Disease ☐ Cancer ☐ Asthma
☐ High Blood Pressure ☐ Migraine ☐ Stomach or duodenal ulcer
☐ High cholesterol ☐ Stroke ☐ Epilepsy
☐ Diabetes ☐ Blood clots ☐ Depression / Anxiety

**OTHER ILLNESS / SURGERY:** Please provide details: ……

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Government HPP legislation now requires your permission to obtain information about you and your condition and to forward relevant details to your referring practitioner and other providers as required.

### BY SIGNING THIS FORM, YOU AGREE:

- TO PAY IN FULL all accounts owing on the day. WE DO NOT BULK BILL AND WILL NOT ISSUE ACCOUNTS
- For our practice to obtain information about you, to access **MYHEALTH** records and your condition and to forward any relevant details to your referring practitioner and other medical providers, as necessary. This includes sending and receiving personal information from DHHS, including your Medicare number, name, and DOB.
- To assign the Medicare benefit directly to the provider, where applicable. We will also electronically claim all rebatable benefits with Medicare on your behalf.
- You may require further tests on the day, which do not attract a rebate from Medicare and therefore will be out of pocket. If you are concerned about the additional costs, please speak with one of our staff members.

Full Name: _____

Signature: _____Date: _____