CAIRNS EYE & LASER CENTRE

PATIENT INFORMATION

(NAME MUST BE AS IT APPEARS ON YOUR MEDICARE CARD)

MR /MRS/MS/MISS/MST/DR/OTHER_____ (Title Optional)

SURNAME: _____

FIRST NAME: _____ **FULL MIDDLE:** _____

GUARDIAN/ POWER OF ATTORNEY/PARENT (if under 18yr): _____

DATE OF BIRTH: _____

RESIDENTIAL ADDRESS: _____

_____

POSTAL ADDRESS (If different from above):_____

_____

TELEPHONE: **(H):** _____ **(W):** _____

(M): _____ **Text Opt in: Yes** ☐ **No** ☐

EMAIL: _____

NATIONALITY/ORIGIN: _____

OCCUPATION: _____

IF <u>RETIRED</u> PREVIOUS OCCUPATION: _____

MEDICARE No: _____

REF (Number next to Name): _____ **EXPIRY:** _____

DVA GOLD CARD No: _____ **EXP:** _____

PENSION CARD No: _____ **EXP:** _____

HEALTH CARE CARD No: _____ **EXP:** _____

COMMONWEALTH SENIOR HEALTH CARD: YES/NO

YOUR GENERAL PRACTITIONER: _____

YOUR OPTOMETRIST: _____

OTHER SPECIALISTS: _____

PRIVATE HEALTH INSURANCE FUND: _____

MEMBERSHIP NO: _____ **LEVEL OF COVER:** _____

EMERGENCY CONTACT NAME: _____

PHONE: _____ **RELATIONSHIP:** _____

GENERAL HEALTH
TICK WHERE APPLICABLE

- ○ HIGH BLOOD PRESSURE
- ○ HEART PROBLEMS/PAIN
- ○ LUNG/CHEST PROBLEMS
- ○ ASTHMA/BRONCHITIS
- ○ EPILEPSY
- ○ RHEUMATIC FEVER
- ○ BLEEDING PROBLEMS
- ○ HEPATITIS A B C
- ○ DIABETES
- ○ ANAEMIA
- ○ ARTHRITIS
- ○ HIGH CHOLESTEROL
- ○ SMOKER
- ○ HIV
- ○ DEMENTIA/ALZHEIMER'S

EYE HISTORY

- ○ EYE SURGERY
- ○ GLAUCOMA
- ○ PREVIOUS EYE INJURY
- ○ PREVIOUS EYE INFECTION
- ○ CONTACT LENS

CURRENT MEDICATION

_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____

PREVIOUS ANAESTHETIC COMPLICATIONS – YES / NO

_____
_____
_____
_____
_____

PLEASE NOTE: This practice does <u>NOT BULK BILL.</u> Payment is required on the day of consultation. Please turn the page, READ and SIGN the section on our privacy policy

PAYMENT IS REQUIRED ON THE DAY OF CONSULTATION.

GOVERNMENT REGULATIONS REQUIRE A CURRENT LETTER OR REFERRAL FROM A GENERAL PRACTITIONER OR OPTOMETRIST TO CLAIM YOUR REBATE BACK FROM MEDICARE.

The provision of quality health care requires doctor-patient relationship of trust and confidentiality. Consistent with our commitment to quality care this practice has developed a policy to protect patient privacy in compliance with privacy legislation.

The Cairns Eye & Laser Clinic would like you to be aware of the following:

In the collection of your personal information, there may be times where another health party will need to have information about you in order to provide a complete, holistic approach to your health care. There are some necessary purposes of collection for which information will be used beyond providing health care, such as professional accreditation, clinical auditing, finalization of accounts and so forth.

Should you have any queries, please feel free to take one of our brochures "Your Privacy – Our Policy" or speak directly to your doctor or one of the staff. If at any time you feel uncomfortable with regard to the collection of your personal information, please feel free to mention it.

In signing below, you agree to our Privacy Policy on the collection of your personal information and in the event of a debt you agree to pay any commission generated on the debt collected on your behalf by our nominated debt collection agency.

☐ **I have read the new patient information letter and practice brochure.**

……..
Print Name

…….. ……..
Signature Date