THE CENTRE
FOR EYES

First Name:	Surname:	Mr Miss Master Mrs Ms Dr
Date of Birth: / /	Home Phone:	Mobile:
Address:	Suburb:	Postcode
Occupation:	Country of Birth:	Work Phone: Email:

Diabetic:☐NO ☐YES ☐NON INSULIN DEPENDENT ☐INSULIN DEPENDENT Do you have Glaucoma:☐NO ☐YES Do you have Cochlea Implant:☐NO ☐YES	Defibrillator: ☐YES ☐NO Or Pacemaker (Please provide details)
List any Medications:	
List any Allergies:	List any Vitamins/Supplements:

Name of next of kin:	Relationship:	Phone number:
Medicare No: (10 digits)	Reference No:	Expiry Date:
Private Health Insurance Fund:	Number:	Number on card:
Pension: ☐ YES ☐ NO	Pension No:	Valid to:
DVA Gold Card: ☐ YES ☐ NO	DVA Number: NX	

Your General Practitioner Details:

Surname:	First Name:
Address:	Phone number:

Referring Doctor or Optometrist Details:

Surname:	First Name:
Address:	Phone number:

PRIVACY INFORMATION AND PHOTO CONSENT FORM:

We require your consent to collect personal information about you to be used solely for administration purposes of this practice and to comply with Medicare, Health Insurance Commission and Medical Insurance requirements. The information will enable your doctor to assess, diagnose and treat your illness properly, liaise with your other doctors and be pro-active in your health care needs. Your doctor may need to take a photograph to assess and follow the progress of your treatment.

I have read the information above and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information. I give my consent to my doctor and his practice staff to collect and use my health information for the purpose of providing health care to me.

Patient Signature: .... Date: ....

☐ Please tick if you do not give your doctor consent to use any photograph taken or patient data as part of a medical or educational presentation or publication, or to contact you about other services offered by this practice.