EYE AND RETINA
SPECIALISTS
Green Square

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HealthLink ID: eyeretin
Suite C1, 30 - 36 O'Dea Ave
Waterloo NSW 2017

Patient Registration Form

Title: Mr / Mrs / Miss / Ms / Master / Dr / Other .....

First/Middle Names..... Last name.....

Residential Address .....

Suburb ..... Postcode .....

Postal Address (if different to residential)

.....

Date of Birth ..... Occupation .....

Home Phone ..... Work Phone .....

Mobile .....

Email .....

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No. _____ Expiry Date: .....

Health Insurance – Private Fund .....Membership No: .....

DVA Card Colour: ..... DVA No: .....

Pension No: ..... Expiry Date: .....

Optometrist ..... Address .....

General Practitioner (*Required*)..... Address.....

Details of other Doctors involved in patient's care

Dr ..... Type of Doctor .....

Address / Suburb.....

Dr ..... Type of Doctor .....

Address / Suburb... .....

Next of Kin (NOK) ..... Relationship ..... Telephone: .....

Email..... Do you give permission to contact NOK if required? Yes / No

I understand Eye and Retina Specialists is a Private Practice and all consultations with the doctor will attract a consultation fee with possible additional test and procedure fees. I certify that all information provided is true and correct and I accept all responsibility and liability for my medical bills. I understand that any additional costs that have to be made for recovery of these fees are my responsibility.

Signature: ..... **Date:** .....

Please turn page over >>>>>>>>>>>>>>>>

Please turn page over >>>>>>>>>>>

Patient Medical Information

Do you have a history of … (please circle) ?

Asthma …….. Yes No

Diabetes ……. Yes No

High blood pressure …….. Yes No

Prostate enlargement…….. Yes No If yes, have you ever been on Flomax? Yes No

Stroke or TIA…… Yes No

Migraines…….. Yes No

Glaucoma ……. Yes No

Eye operations/ injury …….. Yes No Details……..

……

Other medical conditions ……

……

Please list medications you are currently taking:

…….. ……..

…….. ……..

…….. ……..

…….. ……..

Any known drug allergies? If yes, please provide details:

Medication: Reaction:

…….. ……..

…….. ……..

Do you wear contact lenses? Yes No

Do you wear glasses for TV or long distance? Yes No

Do you wear reading glasses? Yes No

Are you on Aspirin, Warfarin, Astrix, Plavix or other blood thinning medications? Yes No

Consent for Educational & Promotional Use

Unless declined below, I consent to photographs, videos, clinical images, and scans obtained during my care being used for medical education, staff training, research, and practice promotional purposes, including on social media.

□ I do not consent to the use of my photographs, videos, clinical images, or scans for these purposes.

Signature: …… **Date: ……**

To benefit your care, it is practice policy to provide correspondence to your referrer, optometrist and/or other relevant doctors. We do not use encrypted email and cannot guarantee confidentially of information sent by email. Please discuss this during your consultation if you have any questions or concerns.