Casey Eye Centre

Patient Registration Form

Patient Details

Title: Mr Mrs Ms Miss Dr Other:_____ *Please circle* Gender: _____

Surname: _____Given Name(s):_____ Date of Birth: ___/___/____

Address: _____Suburb: _____ Postcode: _____

Contact Numbers (H): _____ (W): _____ (M): _____

Email: _____ Occupation: _____

Next of Kin: _____Relationship: _____Ph: _____

Account Details

Medicare: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: ____ (number next to your name)

Concession/Pension Card: CRN: _____

DVA Card: _____ Type of card: Gold/White

Parent/Guardian Information (If patient under 16 years of age)

Full Name: _____ ***Medicare:*** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ***Ref:*** ____

Date of birth: ____/_____/____

Private Health:

Private Health Fund: _____ Membership Number: _____

Level of Hospital Cover: Gold / Silver / Bronze (Please circle)

Staff may perform a check with your health fund on your eligibility for surgery during your consultation if indicated. If you do not wish for staff to perform this check, please advise before your consultation.

This is a private billing practice and there will be out of pocket costs for consultations and procedures. Payment is required at the conclusion of your consultation. It may be necessary to perform further tests, scans, or procedures during your consultation. These will attract fees above the advised consultation fee. Fees can be obtained from reception.

Workcover/TAC claims: Any WorkCover or TAC claims are your responsibility until such time as a claim number is provided or an agreement in writing from your employer is presented. You will be required to pay any costs up front and seek reimbursement from your employer until this time.

Private Health Insurance: Consultations and procedures performed in the clinic do not attract rebates from private health insurers. Procedures performed in hospital may attract benefits from your private health fund. It is your responsibility to check you are covered for the relevant procedures prior to them being performed.

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Interpreter

Do you need an interpreter at your consultation? Yes No If so which language? _____

Health Providers

GP Name: _____Practice: _____

Address: _____Phone: _____

Optometrist (if not referred from optometrist): _____

Other relevant specialists: _____

It is recommended you do not drive for at least two hours following your appointment(s) as your vision will be blurry from the dilating drops. You should not drive until your vision has fully returned to normal.

Please read the following and sign below:

Referrals:

I am aware I need to provide a valid referral in order to claim Medicare rebates for my consultation(s). It is my responsibility to ensure I have a valid and up to date referral for all appointments, and that the clinic is provided with this referral before my consultation. Referrals from optometrists or general practitioners are valid 12 months from first consultation, but referrals from other specialists are valid only for 3 months.

Privacy and health information:

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details so that we may properly access, diagnose, treat your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times your health information is treated with utmost confidentiality.

I have read and understand this form and have provided true and correct information:

Name:_____ **Signature:**_____**Date:**_____