Gippsland 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: _____

Next of Kin: _____Relationship: _____Ph: _____

Account Details

Medicare: __ __ __ __ __ __ __ __ __ __ __ Ref: __ Pension: CRN _____

DVA (Dept of Vet Affairs) if applicable: _____

Private Health Fund: _____ Membership Number: _____
(Please list hospital cover only)

Health Providers

GP Name: _____Practice: _____ Ph: _____

Other relevant providers names: (Specialists, optometrists etc): _____

It is recommended you do not drive for at least two hours following your appointments as your vision will be blurry from the dilating drops. You should not drive until your vision has fully returned to normal. Allow 1-2 hours for your appointment.

Please read the following and sign below:

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, 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.

I am aware that payment is required at the conclusion of my consultation. This is a private billing practice and there will be out of pocket costs for consultations and procedures. Fees can be obtained from reception.

Any WorkCover or TAC claims are my responsibility until such time as a claim number is provided or an agreement in writing from my employer is presented. I will pay any costs up front and seek reimbursement from my employer until this time.

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 the above:

Name:_____ Signature:_____Date:_____