North Shore Eye Centre

ABN: 20 493 066 959

Surname:					
Given Name(s):			*Known as:*		
Date of Birth:			*Gender:*		
Street Name & Number:					
Suburb:		*State:*		*Postcode:*	
Phone (H):		*Mobile:*			
Email:					
Marital Status:	☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Divorced* ☐ *Separated* ☐ *De Facto*				
Occupation:					
Medicare Number:			Ref # (name position on card):		
Private Health Insurance:	☐ YES ☐ NO	Fund:		Membership No:	
Veteran Affairs Number:			White or Gold:		
Pension Card No:			Expiry Date:		
Emergency Contact:	Name:		Relationship:		
	Telephone:				
General Practitioner: ☐ Referred by GP	Name:		Phone:		
	Address:				
Optometrist: ☐ Referred by optometrist	Name:		Phone:		
	Address:				
Referred to Surgeon by: ☐ As above	Name:		Phone:		
	Address:				
Other Specialists:	Name:		Phone:		
	Specialty:				
	Address:				

MEDICAL HISTORY		
Are you diabetic?	☐ YES ☐ NO	List any relevant Family History:
Insulin dependent?	☐ YES ☐ NO	
Year diagnosed?		
Allergies:		
Reaction to anaesthetic?	☐ YES ☐ NO	
List previous operations, serious illness and dates:		

PLEASE TURN OVER

North Shore Eye Centre

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Please complete the following if patient is under 18 years old									
ACOUNT HOLDER DETAILS:									
☐ *Mr*	☐ *Mrs*	☐ *Ms*	☐ *Miss*	☐ *Master*	☐ *Dr*	☐ *Prof*	☐ *Sr*	☐ *Fr*	
Surname:									
Given Name(s):						*Medicare Number:*			
Date of Birth:						*Position on card:*			
Street Name & Number:									
Suburb:			*State:*		*Postcode :*				
Phone (H):				*Mobile:*					
Email:									

PATIENT PRIVACY CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

North Shore Eye Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice who have treated you or may treat you in the future. This may occur through referral to other doctors, hospital emergency departments or for medical tests and in the reports or results returned to us following the referrals. If these providers share information with us, this will also form part of your clinical record.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice. I understand that this consent is inclusive of being contacted via SMS (mobile text message) for appointment reminders and recall reminders unless I specifically state otherwise.

Signed …….. Date: ……

Patient Name (Block Letters): ……