BAYSIDE
EYE SPECIALISTS

Patient Registration Form

Please complete this form and present it to our receptionists on arrival. The information in this questionnaire is confidential. Some of the questions are of a sensitive nature; however this assists in improving the effectiveness of your consultation. Please refer to our Privacy Policy located at reception for further information.

Patient Details

Preferred title (Mr, Mrs, Miss, Ms, Dr, Prof): ..... Surname: .....

First name: ..... Middle name: .....

Preferred name (what you like to be called): ..... Date of Birth: ___/ ___/_____

Street Address: .....Suburb: .....Postcode: .....

Phone: (H) ..... (W) ..... (M) .....

Email address: .....

Next of Kin / contact person in an emergency: .....

Relationship: ..... Telephone: .....

Optometrist: .....Address: .....

GP: ..... Address: .....

Are any other doctors involved in your care, eg cardiac specialists? Yes ☐ No ☐

Specialists Name: .....

Address: .....

Specialists Name: .....

Address: .....

Medicare details Ref No: Expiry:

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If patient is under 18 years old, please complete this section for person responsible for account:

Name: ..... Relationship: ..... Date of birth: ___/ ___/_____

Medicare Number: Ref No: Expiry:

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Veterans Affairs Card Gold

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Private Health Insurance

Health Fund: ..... Membership number: .....

Benefit Details

Type of Pension (e.g. Aged Pension/Disabled Pension): .....

Customer Reference Number: ..... Expiry Date: ___/ ___/_____

Bayside Eye Specialists 323 Nepean Hwy, Brighton East VIC 3187
T 03 9596 7440 **F** 03 9596 7440 **E** info@baysideeyes.com.au **www.baysideeyes.com.au**

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Third Party Claims: TAC ☐ **Workcover** ☐ **Claim Number:** ……

Insurance Company Address: …….....

Employer's Name (If Workcover): …….....

Please list any forms of medications you take, amount & frequency of dosage:

……

……

……

Please list any allergies or sensitivities:

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……

……

Please list any previous surgical procedures and year of surgery:

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Appointments usually take 1-2 hours. Your eyes may be dilated with drops which will make your vision quite blurry, so we recommend that you do not drive home. Please read the following and sign, indicating that you understand and agree.

This medical practice collects information from you for the primary purpose of providing quality health care. This information is used for administrative purposes, disclosure to others involved in your health care and for referral to other doctors or medical tests. This practice has a privacy policy on handling patient information.

This practice is a teaching facility; therefore students may be in attendance during your consultation. Please advise reception if you do not want them present.

Photographs and scans may be taken of your eyes at Bayside Eye Specialists. These form part of your medical records. Copies of the photographs may also be sent to your referring practitioner, and in some cases, used for teaching, research or publication in scientific journals.

I have been informed of the costs involved and understand that payment of the account is my responsibility.

I am also aware that in order for me to claim a Medicare rebate I will need to provide a valid referral to my doctor on the day of consultation.

Your signature authorizes us to send you emails and SMS (mobile text message) for: appointment reminders, recalls and other reminders or medical services we offer.

Patient Signature: …….… **Date:** ___/ ___/____

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