VISION EYE INSTITUTE

REGISTRATION FORM

PATIENT DETAILS

Title:

Given name(s):

Preferred name:

Surname:

Date of birth (DD/MM/YYYY):

Residential address:

Suburb:

Postcode:

Postal address (if different from above):

Suburb:

Postcode:

Home Phone:

Work Phone:

Mobile:

E-mail:

Occupation:

Country of birth:

Language(s) spoken:

Are you of Aboriginal and/or Torres Strait Islander descent?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander ☐ No ☐ Refuse to answer

If patient is a child under 18 years:

Do you have the same Medicare card? ☐ Yes ☐ No

Form continues over page >

ADDITIONAL INFORMATION

Medicare number:

Ref number:

Expiry date (MM/YY):

Pension Card/Health Care Card number:

Expiry date (MM/YY):

Veterans Affairs number:

Gold/White card:

Private health fund details

Name of insurer:

Membership number:

Emergency contact

Full name:

Relationship to patient:

Phone number:

General practitioner details

Doctor's name:

Phone number:

Address:

Suburb:

Postcode:

Optometrist details

Name:

Phone number:

Address:

Suburb:

Postcode:

Is this consultation related to workers' compensation? ☐ Yes ☐ No

Is this consultation related to a TAC claim (VIC only)? ☐ Yes ☐ No

Claim number:

Date of accident (DD/MM/YYYY):

Name of insurer:

How did you hear about Vision Eye Institute?

☐ GP ☐ Optometrist ☐ Relative/friend ☐ Google/online search ☐ Other (please specify):

VISION EYE INSTITUTE

CONSENT FORM

PRIVACY POLICY AND OBSERVATION CONSENT

By signing this form, I acknowledge that:

- I have been provided with access to the Vision Eye Institute Privacy Policy (available at https://visioneyeinstitute.com.au/privacy-policy/).
- I am aware Vision Eye Institute will store and use my records in the ways described in the policy.
- If I wish to access my medical records, I must make a written request to Vision Eye Institute and I am aware that an administrative fee may be incurred.
- I am aware that Vision Eye Institute has the ability to send correspondence to my current referrer electronically and that every effort will be made to ensure the security of my data.
- I agree to receiving electronic correspondence to the email address and mobile phone number provided on this form.
- I understand that correspondence or data relating to my care may be sent to relevant health authorities.
- I understand that an observer may be present during my consultation/procedure and that my medical treatment will remain confidential.

THIRD-PARTY CONSENT

I give permission for my carer/relative/friend to discuss my personal information (e.g. appointments, invoices, medical information) with clinic staff and I give permission for Vision Eye Institute to provide this information to my carer/relative/friend.

☐ Yes ☐ No

FEES

Vision Eye Institute is a private ophthalmology clinic and there will be costs associated with your appointment that relate to diagnostic testing required by your doctor to assess your eyes. The cost of these tests is not always claimable through Medicare and is payable in full on the day of the appointment. Consultation fees are eligible for a Medicare rebate if you have a current referral letter from your GP or optometrist.

By signing this form, you acknowledge that fees are payable on the same day.

Please advise staff if you do not agree to any of the above.

Patient/guardian printed name:

Patient/guardian signature:

Date: