Patient Registration Form

(Please complete in Black Pen Only)

Central Lakes EYE CLINIC

By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.
I certify that I have read or had read to me the Initial Appointment Brochure provided by Central Lakes Eye Clinic and understand the costs & procedures involved and agree to proceed with initial and subsequent consultations. I also understand that all tests and measurements are non-refundable. I understand that this practice is NOT a Bulk Billing Practice and I am responsible for full payment for all services rendered on the day of my appointment and that if I am an Inpatient at the Caboolture Private Hospital I am responsible for full payment of all services rendered on the day of my appointment. I also understand that if a third party (eg. Work cover) is covering the cost of my consultation and they refuse to pay that I will be responsible for the full cost of all services rendered on the day of my appointment.
I authorise this practice to release any of my personal/medical information (released via fax, post, email and medical-objects) including the diagnosis, and the records of any treatment or examination to any required professionals or institutions including my GP and Optometrist as seen fit by my treating specialist. A copy of CLEC's patient privacy policy is available to be viewed at the reception desk on request. I understand that a new referral is required every 12 months (3 months for referrals from specialists). It is my responsibility to ensure that my current referral will be valid for my appointment. If your referral is expired, the doctor at Central Lakes Eye Clinic will not be able to see you until a valid referral is provided.

_____ _____

SIGNATURE: **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

Next of Kin/Emergency Contact:

Contact Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

GP Name: _____Address:_____

Optometrist Name: _____Address:_____

Insurance Information:

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Pension Card: _____ Expiry Date:_____

Private Health Provider: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:

☐ Hospital (Full) ☐ Hospital (Basic) ☐ Extras Only ☐ Combined (Full) ☐ Combined (Basic)

Department of Veterans Affairs:

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

PLEASE TURN OVER

Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Central Lakes Eye Clinic for:

_____

_____

_____

Have you had any previous Eye Surgery: _____

Which specialist did the surgery: _____

Medication: If you are using any current <u>eye</u> medication, please select from the following list:

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

List of any other current Medication including and Blood Thinners:

Relevant Medical Conditions (Please tick the correct columns below):-

	NO	YES	
High Blood Pressure			
Diabetes **Do you know your sugar levels?**			**Type 1 ☐ or Type 2 ☐** **HBA1C Levels (6monthly)_____**
Rheumatoid Arthritis			
Renal (Kidney) Failure			
Heart Problems			
Blood Clots			
Uncontrolled Asthma			
Thyroid Problems			
Bleeding or bruising disorder			**INR Level_____**
Epilepsy or convulsions			
Cognitive Impairment			
Rheumatic Fever			
Stroke TIA Fainting attack			
Sleep Apnoea			
Chronic bronchitis emphysema			
Hepatitis C, Hepatitis B, HIV			**If yes, which one?_____**
Heartburn or acid reflux			
Smokers Status			**If yes, how many cigarettes per day _____**
Other:			

Allergies:

PLEASE READ AND SIGN THE TOP OF PAGE 1