WesternEyeSpecialists

Patient Registration form

SURNAME:		Date of Birth:
FIRST NAME:		□Mr □Mrs □Miss □Mast □Ms □Dr
ADDRESS:		
		Postcode
Tel Home:	Tel Mobile:	Email:
In Case of Emergency contact name		Emergency Telephone

IF CHILD UNDER 16 ONLY

Parent Surname ______________________________ First name ______________________

Parent Medicare No: Ref No next name [| | | | | | | | | | XXXX |] Parent Date of Birth ______________________

Patient Medicare No: [| | | | | | | | | | XXXX |]	Ref No next to your name	Expiry
Pension/ Veterans / Health Care Card No: [| | | | | | | | |]		Expiry
Private Health Insurance (**HOSPITAL COVER ONLY**)	□ YES □ NO	
Name of Health fund:	Member No:	

Your doctor details (GP)	Name: Address:	Tel
Other Doctors involved in your primary care eg: physician/endocrinologist	Name: Address: Name: Address:	Tel Tel
Optometrist ***if applicable***	Name: Address:	Tel

Is this visit related to a Motor Accident or Work Cover Claim? □ YES □ NO

If yes Name/Address of Company ____

Date of accident ______________________________ Claim No: ______________________________

I allow Western Eye Specialists to forward any relevant medical information to other practioners involved in my medical care. □ YES □ NO

PTO

Signature ____ *Date:* __________________

HEALTH QUESTIONNAIRE

Date:____/_____/20___

Do you have any family ocular history? ie macular degeneration, glaucoma

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Do you have any past ocular history including eye surgery?

Do you have any medical conditions?

Please list your current medication/s

Do you have any allergies?