CONFIDENTIAL INFORMATION

Parkville Eye Specialists

**CAN BE FORWARED VIA EMAIL PRIOR TO APPOINTMENT: reception@parkvilleeyespecialists.com.au

PERSONAL INFORMATION

TITLE: (Please Circle) MISS MS MRS MR OTHER

PATIENT SURNAME: ……

PATIENT GIVEN NAME: ……

(As printed on your MEDICARE Card)

By what name would you like us to call you? ……

DATE OF BIRTH: ……/……/…… MALE / FEMALE

ADDRESS: ……

…… POSTCODE: ……

TELEPHONE NO: HOME: ……WORK: ……

MOBILE: ……

EMAIL ADDRESS: ……

Please confirm that you are happy to receive communication by email: YES / NO

YOUR MEDICARE / VETERAN AFFAIRS DETAILS PLEASE

PATIENTS MEDICARE NO: ……

MEDICARE REF NO: (The number beside your name) …… EXPIRY DATE: ……

VETERAN AFFAIRS NUMBER: ……

GOLD CARD / WHITE CARD EXPIRY DATE: ……

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME: ……RELATIONSHIP: ……

HOME PHONE: …… MOBILE: ……

DO YOU HAVE PRIVATE HEALTH INSURANCE?

FUND: ……

MEMBER NUMBER: ……

PLEASE CONTINUE OVER PAGE

Parkville Eye Specialists

MEDICAL HISTORY

REFERRING DOCTORS NAME: ……

ADDRESS: ……

TELEPHONE: ……

LOCAL GP NAME & CLINIC: (if different from referrer)……

ADDRESS: ……

TELEPHONE: ……

OPTOMETRIST NAME: (if you have one)……

ADDRESS: ……

TELEPHONE:……

PRIVACY STATEMENT

THE INFORMATION PROVIDED ON THIS FORM IS COLLECTED FOR THE PURPOSE OF PROVIDING COMPREHENSIVE HEALTHCARE, THIS INFORMATION WILL BE RETAINED ON THE PATIENT RECORD AND KEPT CONFIDENTIAL. THE PATIENTS RECORD MAY HOWEVER BE DISCLOSED TO A THIRD PARTY INVOLVED IN THE CARE AND UNDER CERTAIN CIRCUMSTANCES – WHERE REQUIRED BY LAW OR WHEN REQUESTED BY ANOTHER MEDICAL PRACTITIONER/HOSPITAL INCLUDING EMERGENCY MEDICAL CARE

CLINICAL PHOTOGRAPHY

PHOTOGRAPHS OR VIDEOS MAY BE TAKEN TO RECORD CLINICAL FINDINGS. THESE MAY BE USED FOR:

1. **DOCUMENTING YOUR MEDICAL HISTORY**
2. **THE TEACHING OF HEALTH PROFESSIONALS AND STUDENTS STUDYING HEALTHCARE HERE AND IN OTHER HOSPITALS/COLLEGES/UNIVERSITIES**
3. **THE EDUCATION OF PATIENTS WITH CONDITIONS SIMILAR TO YOURS. IF PUBLICATION IN MEDICAL AND SCIENTIFIC JOURNALS OR TEXTBOOKS IS CONSIDERED YOU WILL BE CONTACTED TO OBTAIN SPCIFIC WRITTEN PERMISSION.**

FINANCIAL CONSENT

I UNDERSTAND THAT I WILL INCUR OUT OF POCKET EXPENSES AND THAT THE FEES ARE DUE AND PAYABLE ON THE DAY OF CONSULTAION.

NOTE: MINIMUM 24HRS NOTICE REQUIRED FOR CANCELLATION OR NON ATTENDANCE, OTHERWISWE CANCELLATION FEE APPLIES.

PLEASE SIGN TO CONFIRM YOU HAVE READ AND UNDERSTOOD THE PRIVACY STATEMENT/PHOTOGRAPH AND FINANCIAL CONSENT

SIGNATURE: …… **DATE: ……..**