ADULT PATIENT INFORMATION SHEET

Dr / Mr / Mrs / Ms / Miss / Master / Other _____

First Name: _____ SURNAME: _____

Date of Birth: _____

Telephone(H): _____ Mobile: _____

Address: _____

Suburb: _____ Post Code: _____

Postal address *(if differs to above)* email: _____

Address: _____

Occupation: _____

Emergency Contact: _____ Mobile: _____

Work Cover
Insurer: _____ Claim No: _____

Medicare and Private Health Fund Details

Please hand your Medicare / Pension and Private Health Fund cards to Reception to enter the information into your record

Referring Doctor / Optometrist / Other Medical Professionals involved in the Patients Care (PLEASE include Address)

Referring Doctor: _____

Optometrist: _____

Family Doctor: _____

Report copy to: _____

I understand that Eye and Laser Surgeons is a Private Practice and all consultations with a Doctor will attract a consultation fee with possible additional test and procedure fees. I certify that all information provided is true and correct and I accept all responsibility and liability for the medical bills associated with my consultation and understand that any additional costs that have to be made for recovery of these fees are my responsibility.

Privacy Policy: All personal information collected by Eye and Laser Surgeons is treated in accordance with '*The Privacy Act 1998*' and '*Australian Privacy Principles'*. I acknowledge that my eye Doctor will be releasing my eye health information to the Medical Practitioners listed above.

_____ _____

Signature: Date: