ADELAIDE EYE & LASER CENTRE
A CLEARER BRIGHTER FUTURE

PATIENT REGISTRATION FORM

Please complete both sides of this form prior to your appointment and return to reception staff. The information collected on this form will assist us to facilitate the provision of your care and/or meet legislative requirements.

If you require assistance with this form, please see reception staff.

Interpreter Service: *Please advise our staff if you require an interpreter to be present at your consultation. Services are provided for most languages and 72 hours notice is required*

PERSONAL DETAILS

☐ Dr	☐ Mr	☐ Mrs	☐ Ms	☐ Miss	Other ……	☐ Male	☐ Female

Marital Status: ☐ Single ☐ Married ☐ De Facto ☐ Widowed ☐ Divorced ☐ Separated

Surname:	Given Names:
Previous Name: (if changed from last visit)	Preferred Name:

Address:	State:	Postcode:
City/Town/Suburb:		
Date of Birth: / /		

Home phone:	Work phone:	Mobile phone:

Email address:

Country of Birth:	Occupation:

Are you of Aboriginal or Torres Strait Islander origin?

☐ No	☐ Yes, Aboriginal Descent	☐ Yes, Torres Strait Islander

Please provide below details: ☐ **Next of Kin** ☐ **Responsible Person** ☐ **Power of Attorney** **(as defined in the National Privacy Principles)**

Name:	Relationship:
Address:	

Home phone:	Work phone:	Mobile phone:

Authority to contact the above named regarding:	☐ Emergency	☐ Yes	☐ No	Please initial ……
	☐ Outcome of treatment	☐ Yes	☐ No	Please initial ……
	☐ Account/Fund matters	☐ Yes	☐ No	Please initial ……

HEALTH CARE CARDS (Please enter details below and present relevant cards to reception)

☐ Pension Card/Health Care Card	Card Number:	Expiry Date:			
☐ Commonwealth Seniors Card	Card Number:	Expiry Date:			
☐ Pharmacy Card	Card Number:	Expiry Date:			
☐ Safety Net Entitlement Card	Card Number:	Expiry Date:			
☐ Dept of Veterans' Affairs (DVA) Card	Card Number:	Expiry Date:			
	DVA Card Colour	☐ Gold	☐ White	☐ Orange	

MEDICARE CARE CARD INFORMATION

Medicare Card Number:

Reference Number beside patient name:	Expiry Date:

If you have not provided a Medicare number in the space above, please indicate below if this is because you:

☐ Do not know the number or have not yet been issued a card OR	☐ Are not eligible to receive a Medicare card

If you are a visitor to Australia, have you been issued with a Medicare card stating "VISITOR RHCA"	☐ YES	☐ NO	☐ N/A
Have you applied for permanent resident status and your Medicare card states "INTERIM CARD"	☐ YES	☐ NO	☐ N/A

HEALTH FUND INSURANCE DETAILS (Completion of this section will authorise use of particulars for eligibility checking and invoicing purposes).

Do you have private health insurance?	Hospital: ☐ YES ☐ NO	Excess amount if applicable $.....	Extras: ☐ YES ☐ NO

Name of Health Fund:		Membership Number:
Restrictions: ☐ YES ☐ NO	Exclusion for eye surgery: ☐ YES ☐ NO	Do you have ultimate or ultra cover? ☐ YES ☐ NO (Bupa/Medibank Private Members only)

WORKERS COMPENSATION/THIRD PARTY/PUBLIC LIABILITY CLAIM ☐ YES ☐ NO

If YES, please see reception staff for additional form.

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PATIENT REGISTRATION FORM (CONT)

GENERAL PRACTITIONER / LOCAL DOCTOR DETAILS		
Full name of Doctor:		
Clinic Name:		
Address:	State:	Postcode:

OPTOMETRIST DETAILS:		
Full name of Optometrist:		
Clinic Name:		
Address:	State:	Postcode:

Have you presented a referral to reception staff ☐ YES ☐ NO: If so, please indicate ✓ ☐ GP / ☐ Optometrist / ☐ Specialist

If referring practitioner is different to that stated above, please provide details below.

Full name of referring practitioner:		
Clinic Name:		
Address:	State:	Postcode:

OTHER INFORMATION

The main reason I am considering refractive/cataract surgery is:

Please list the most important tasks that you require good vision (eg: for work, at home or recreation):

Please indicate if you have received a copy of the "Useful Information" leaflet: ☐ YES ☐ NO

You may obtain details of our Privacy Policy from the Reception area.

Do you require to speak with our staff regarding any information you have received? ☐ YES ☐ NO

Please indicate below how you heard about us:

☐Family/Friend	☐Optometrist	☐Radio Nova	☐Athlete-Jordan Steffens	☐White Pages	☐Website
☐Facebook/Social Media	☐Doctor/Specialist	☐Radio 5AA	☐Athlete-Jess Trengove	☐Yellow Pages - online	☐Google
☐Lose Glasses campaign	☐Football Budget	☐Radio Fresh FM	☐Sports & Fitness Expo	☐Yellow Pages - book	☐Other……

Consumer Participation

Adelaide Eye & Laser Centre encourages consumer participation to assist in the ongoing quality process including the safety of all consumers (which may include patients and their carers). This may be achieved through various means which include, but are not limited to, survey information post surgery, social media updates or following up on complaints or suggestions. In some instances, patients or carers may also be asked to participate in a brief interview or consultation on quality issues or their overall experience at AE&LC. If you would like to be further involved or have any suggestions or comments, please don't hesitate to speak with our staff.

DECLARATION

I certify that the information contained within this form is true and correct.

……	……	……..
Signature	Print Name in full	Date

Office Use Only: Checked By: _____ Entered By: _____ OPV: ☐