ADELAIDE eye&laser CENTRE

PATIENT REGISTRATION FORM

Please complete 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:					Preferred Name:		
Given Names:							
Postal Address:						State:	Postcode:
City/Town/Suburb:							
Date of Birth: / /			Email address:				
Home phone:		Work phone:			Mobile phone:		
Country of Birth:				Occupation:			
Are you of Aboriginal or Torres Strait Islander origin?							
☐ No		☐ Yes, Aboriginal Descent			☐ Yes, Torres Strait Islander		
Emergency Contact							
Name:		Phone:			Relationship:		
MEDICARE CARE CARD INFORMATION							
Medicare Card Number:							
Reference Number:			Expiry Date:				
If patient under 18 years old:		Name of person account should be addressed:					
Medicare Card Number:			Ref no:	Exp:	DOB:		
HEALTH CARE CARDS (Please enter details below and present relevant cards to reception)							
☐ Pension Card/Health Care Card		Card Number:			Expiry Date:		
☐ Dept of Veterans' Affairs (DVA) Card		Card Number:			Expiry Date:		
		DVA Card Colour			☐ Gold	☐ White	☐ Orange
HEALTH FUND INSURANCE DETAILS							
Do you have private health insurance?		Hospital: ☐ YES ☐ NO			Extras: ☐ YES ☐ NO		
Name of Health Fund:				Membership Number:			
WORKERS COMPENSATION/THIRD PARTY/PUBLIC LIABILITY CLAIM							
☐ **YES** ☐ **NO**		*If YES, please see reception staff for additional form.*					
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:

Please indicate below how you heard about us:

☐Family/Friend	☐Optometrist	☐Radio Nova	☐Hayley Pearson/Adelady	☐White Pages	☐Google
☐Facebook/Social Media	☐Doctor/Specialist	☐ Website	☐ Radio Hit 107	☐Yellow Pages	☐Other .....

DECLARATION

Payment for consultations are payable at the time of your visit. Our account terms require that any outstanding amounts are settled in full within 30 days. Accounts outstanding after this time may be subject to further costs that are incurred as a result of debt collection. I certify that the information contained within this form is true and correct.

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