NEW PATIENT REGISTRATION FORM (11/18)

ADELAIDE EYE & RETINA CENTRE

To assist us in the book-keeping necessary for you to claim Medicare or other rebates, would you please fill in your details below. Please ask for us to assist you if necessary. Your personal information is *confidential.*

PATIENT DETAILS: Mr / Mrs / Miss / Ms / Dr / Other _____

FIRST NAME: _____ **SURNAME:** _____

DATE OF BIRTH: _____ **EMAIL:** _____

PHONE: Mob: _____ Hm: _____ Wk: _____

TEXT MESSAGE REMINDER FOR FUTURE APPOINTMENTS: YES / NO

POSTAL ADDRESS: _____

SUBURB: _____ **POSTCODE:** _____

ETHNICITY: Do you identify as: □ Aboriginal □ Torres Strait Islander □ Both □ Neither

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NEXT OF KIN:
Mr/Mrs/Ms/Miss/Other _____: _____ _____
First Name Surname

RELATIONSHIP to you *e.g. husband/wife/friend etc* _____

NEXT of KIN CONTACT No: Mobile: _____ Home: _____

MEDICARE CARD NO: ___ ___ ___ ___ / ___ ___ ___ ___ ___ / ___

REF NO: _____ *(number on left hand side of your name)* **EXP DATE:** _____ / _____

GOLD CARD VETERANS AFFAIRS (if applicable): _____

PENSIONER CARD NO: __ __ __ __ __ __ __ __ __ __
(not health care/seniors card)

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DO YOU HAVE PRIVATE HEALTH INSURANCE HOSPITAL COVER?: If yes:

NAME OF FUND: _____ MEMBER NO: _____

GP NAME AND/OR CLINIC NAME: _____

YOUR GP ADDRESS: _____

_____

I CONSENT TO ADELAIDE EYE AND RETINA CENTRE COLLECTING AND DISCLOSING MY INFORMATION IN ACCORDANCE WITH THEIR PRIVACY POLICY.

SIGNATURE _____ DATE: _____

I CONSENT TO ADELAIDE EYE AND RETINA CENTRE TO THE ANONYMOUS USE OF ANY PHOTOGRAPHS OR SCANS TAKEN OF THE BACK OF MY EYE IN PRESENTATIONS FOR TEACHING PURPOSES.

SIGNATURE _____ DATE: _____