NEW PATIENT REGISTRATION FORM

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: Mobile:_______________**Home:** ________________ **Work:**_____________

PLEASE INDICATE IF YOU WOULD LIKE A TEXT MESSAGE REMINDER FOR FUTURE APPOINTMENTS: YES / NO

ADDRESS:____

SUBURB: __________________________**POSTCODE:**_________________________

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

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NEXT OF KIN or EMERGENCY CONTACT:

Mr/Mrs/Ms/Miss/Other _______: _______________ ____________________________

First Name Surname

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

PREFERRED CONTACT Number:

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)*

Please turn to page 2

ADELAIDE EYE & RETINA CENTRE

NEW PATIENT REGISTRATION FORM

GP NAME AND/OR CLINIC NAME: ______________________________

GP ADDRESS: ______________________________

PHONE NO: ______________________________

FAX NO: ______________________________

OPTOM NAME AND/OR STORE NAME: ______________________________

OPTOM ADDRESS: ______________________________

PHONE NO: ______________________________

FAX NO: ______________________________

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

NAME OF FUND: ______________________________

MEMBERSHIP NO: ___ ___ ___ ___ ___ ___ ___ ___ ___

I consent to Adelaide Eye & Retina Centre collecting and disclosing my information in accordance with their privacy policy.

Signature ______________________________ **Date:** _______ /______ /______

I consent to Adelaide Eye & 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:** _______ /______ /______

I consent to the use of i-Scribe, a secure medical note-taking tool, during my consultation to assist with accurate clinical documentation.

Signature ______________________________ **Date:** _______ /______ /______