



ADELAIDE EYE & RETINA CENTRE

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: Master / Miss / 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

MEDICARE CARD NO: ____ _ / ____ _ / ____ REF NO: ____

EXP DATE: ____ / ____

PARENT DETAILS:

Mr/Mrs/Ms/Miss/Other _____ : _____
First Name Surname

RELATIONSHIP to patient - *mother / father / carer* (please circle)

PREFERRED CONTACT Number: Mobile: _____ Home: _____

PARENT DATE OF BIRTH: ____ / ____ / ____

PARENT MEDICARE CARD NO: ____ _ / ____ _ / ____ REF NO: ____

EXP DATE: ____ / ____

PENSIONER CARD NO: ____ _

Please turn to page 2

GP NAME AND/OR CLINIC NAME: _____

GP 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:** ____/____/____