NEW PATIENT DETAILS FORM

gordoneyesurgery

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Could you please assist us by completing the following 2 page form:

Surname/s		**Date of Birth**	_ _ / _ _ /_ _ _ _
Title	❑ **Mr** ❑ **Mrs** ❑ **Ms** ❑ **Miss**		
First Name/s			
Known as (if different)		**Previous surname/s:**	
Street Address		**PO Box**	
Suburb and Post Code			
Home Phone		**Work Phone**	
Mobile Phone			
Do you wish to have an SMS/text message reminder sent to your mobile phone? ❑ Yes ❑No *Our practice provides our patients with an SMS/text message reminder to their mobile phone the day prior to each appointment with the date, and time of each appointment and current referral expiry date.*			
Email address			
Medicare Card	__ __ __ __ __ - __ __ __ __ __ __ - __ **Number next to name:** ___	**Expiry**	_ _/_ _
DVA Card ❑ **Gold /** ❑ **White Number**		**Expiry**	_ _/_ _
Pension Card Number (blue)		**Expiry**	_ _/_ _
Health Care Card Number		**Expiry**	_ _/_ _
Private Health Fund Name		**Number**	
GP name, Practice name & telephone number			
Optometrist name & telephone number			
Names of family members also in the practice			
Next of Kin / Emergency contact	(Name and Telephone number of the person we can contact if needed)		
If child, parent/carer name/s			

Have you read and signed our privacy policy?
❑ Yes ❑ No

Do you have a valid referral to bring to your appointment?
It is a requirement by Medicare that to be billed by a specialist and receive the full Medicare rebate you must have a referral AT THE TIME YOU SEE THE SPECIALIST. For more information please contact Medicare 132 011.
❑ Yes ❑ No

Signature of person completing the form		**Date**	_ _ / _ _ /_ _ _ _
Print name		**Telephone**	

PLEASE TURN OVER

Please note FULL PAYMENT IS REQUIRED ON THE DATE OF CONSULTATION.

Comprehensive consultation fees are approximately $220-$290 depending on the nature of your condition, plus any additional measurements that are required, minus any applicable pension discounts and Medicare rebates.

I declare that I understand that the payment for the consult is required IN FULL on the DAY of the appointment:

____________________________(signature)___________________________(name) ________________(date)

If above signed by someone other than the patient:

Name of person responsible for payment *(If not the patient)*	
Telephone & address *(If not the patient)*	
Date of birth and Medicare number including number by name + expiry date *(if you wish the Medicare rebate to go into your account rather than the patient's)*:	_ _ / _ _ / _ _ _ _ __ __ __ __ - __ __ __ __ __ - __ Number next to **name:** ___ Expiry: _ _ / _ _

For our records only:

How did you hear about us?	❑ GP ❑ Optometrist ❑ Specialist ❑ Friend/Relative – Name: ❑ Phonebook ❑ Internet ❑ Health Event/Journal – Name:
Who were you referred to?	❑ Dr Painter ❑ Dr Booth-Mason ❑ Dr Grigg ❑ Other – Name: ______________________
What were you referred for?	❑ Cataracts ❑ Glaucoma ❑ Macula ❑ Cornea ❑ Diabetes ❑ Urgent ❑ Other: ______________________________
Occupation	
Hobbies & Interests	

Worker Compensation Only

Please note: If this information is not available at the time of your appointment you will need to settle the account yourself.

Insurer	
Approval number	
Contact name & number	
Copy of Approval supplied	❑ Y ❑ N

Power of Attorney: copy supplied if applicable: ❑ Y ❑ N

PLEASE TURN OVER