



PATIENT DETAILS									
<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Master <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> Sr <input type="checkbox"/> Fr									
Surname:									
Given Name(s):						Known as:			
Date of Birth:						Gender:			
Street Name & Number:									
Suburb:			State:		Postcode:				
Phone (H):				Mobile:					
Email:									
Marital Status:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> De Facto							
Occupation:									
Medicare Number:					Ref # (name position on card):				
Private Health Insurance:		<input type="checkbox"/> YES <input type="checkbox"/> NO		Fund:		Membership No:			
Veteran Affairs Number:					White or Gold:				
Pension Card No:					Expiry Date:				
Emergency Contact:		Name:			Relationship:				
		Telephone:							
General Practitioner:		Name:				Phone:			
		<input type="checkbox"/> Referred by GP Address:							
Optometrist:		Name:				Phone:			
		<input type="checkbox"/> Referred by optometrist Address:							
Referred to Surgeon by:		Name:				Phone:			
		<input type="checkbox"/> As above Address:							
Other Specialists:		Name:				Phone:			
		Specialty:							
		Address:							
MEDICAL HISTORY									
Are you diabetic?		<input type="checkbox"/> YES <input type="checkbox"/> NO			List any relevant Family History:				
Insulin dependent?		<input type="checkbox"/> YES <input type="checkbox"/> NO							
Year diagnosed?									
Allergies:									
Reaction to anaesthetic?		<input type="checkbox"/> YES <input type="checkbox"/> NO							
List previous operations, serious illness and dates:									



PATIENT PRIVACY CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

North Shore Eye Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice who have treated you or may treat you in the future. This may occur through referral to other doctors, hospital emergency departments or for medical tests and in the reports or results returned to us following the referrals. If these providers share information with us, this will also form part of your clinical record.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice. I understand that this consent is inclusive of being contacted via SMS (mobile text message) for appointment reminders and recall reminders unless I specifically state otherwise.

Signed Date:

Patient Name (Block Letters):