New Patient Registration Form

Patient Details

Preferred title (Mr, Mrs, Miss, Ms, Dr, Prof): …….
First name: …… Middle name: …… Surname: ……
Preferred name (what you like to be called): …… Date of Birth: ……/……./…….

Street Address: ……Suburb: ……Postcode: …….
Phone: (H) …….. (W) …….. (M) ……..
Email address: ……..

Next of Kin / contact person in an emergency: ……..
Relationship: …… Phone: ……

General Practitioner (GP)

Name of doctor: ……Practice name: ……
Address/suburb: …… Post code: ……

Private Health Insurance

Health Fund: …….. Membership number: ……
Expiry date: ……

Veterans Affairs Card

Veteran's Affair No: …….. White/Gold: ……..

Privacy Policy & Observation Consent

Please read the following. By ticking the boxes and signing, you are confirming that you understand and agree.

VisionFirst Surgery collects information from me for the primary purpose of providing quality health care. This information is used for administrative purposes, disclosure to others involved in my health care and for referral to other doctors or medical tests. This practice has a privacy policy on handling patient information. ☐

Photographs and scans may be taken of my eyes and these form part of my medical records. Copies of the photographs may also be sent to my referring practitioner. In some cases, de-personalised photographs, scans, and medical information are used for teaching, research, or publication in scientific journals. ☐

I have been informed of the costs involved and understand that payment of the account is my responsibility. ☐

I am also aware that for me to claim a Medicare rebate I will need to provide a valid referral to my doctor on the day of consultation. ☐

Patient Signature: …… Date: ……/……../……..
If you are under 18, your parent or guardian must sign this document on your behalf. If you are aged between 15 and 18, both you and your parent or guardian should sign.

Guardian Signature: …… Date: ……/……../……..

Medical History

Please list any allergies or sensitivities:

……..

Do you have any of the following medical conditions?

Diabetes Yes ☐ No ☐

If yes, Type 1 ☐ or Type 2 ☐ Your last HbA1C level: ……

Asthma or COPD Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

High cholesterol Yes ☐ No ☐

Stroke Yes ☐ No ☐

Heart disease Yes ☐ No ☐

Cancer Yes ☐ No ☐ If yes, what type of cancer? ……

Any other conditions? ……

Do you take any eye drops? If so, what drops and for which eye?

……..

Please list any other forms of medications you take, amount & frequency of dosage:

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