EMEYES
EAST MELBOURNE EYE SURGEONS

Address
Suite 206
100 Victoria Parade
East Melbourne VIC 3002

t: 03 9662 2330
f: 03 9662 3131

e: admin@emeyes.com.au
w: emeyes.com.au

Patient Information

Please complete this form and present it to our receptionists on arrival. The information in this questionnaire is confidential. Some of the questions are of a sensitive nature, however this assists in improving the effectiveness of your consultation. Please refer to our Privacy Policy located at reception for further information.

Patient Details

Preferred Title

◯ Mr ◯ Ms ◯ Mrs ◯ Miss ◯ Dr ◯ Prof ◯ None

First Name | **Middle Name** | **Surname**

Preferred Name | **Date of birth** (/ /)

Address

Street address:

Suburb/City: Post code:

Home phone | **Work Phone** | **Mobile**

Email

Next of kin or contact person in an emergency | **Telephone** | **Relationship**

Optometrist Name | **Optometrist Address**

General Practitioner Name | **General Practitioner Address**

Are any other doctors involved in your care, eg cardiac specialists? ◯ Yes ◯ No

Specialists Name | **Specialists Address**

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Medicare details (if not already listed, please enter below)

Medicare Number ☐☐☐☐ - ☐☐☐☐☐ - ☐ Ref No ☐ Expiry ☐☐ - ☐☐

Private health fund
(If hospital cover applies)

Membership number

Centrelink benefit details
Type of Benefit
(e.g. Aged Pension/Sickness Benefits):

Customer reference number

Expiry Date

Vetrans Affairs Card ☐☐☐☐☐☐☐☐

Gold ☐

White ☐

Third Party Claims

TAC ☐

Workcover ☐

Claim Number

Insurance Company Address

Employer's Name (if Workcover)

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

Please list any allergies or sensitivities:

Please list any previous surgical procedures and year of surgery:

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If patient is under 18 years of age, please complete this section for person responsible for account:

Name

Relationship

Date of birth

Contact number

Medicare details (if not already listed, please enter below)

Medicare Number ☐☐☐☐-☐☐☐☐☐-☐ Ref No ☐ Expiry ☐☐-☐☐

You will be here for 1-2 hours. Your eyes may be dilated with drops which will make your vision quite blurry, so we recommend that you do not drive home. Please read the following, and sign if you agree.

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

This practice is a teaching facility; therefore students may be in attendance during your consultation. Please advise reception if you do not want them present.

Photographs and scans may be taken of your eyes at our clinic. These form part of your medical records. Copies of the photographs may also be sent to your referring practitioner, and in some cases, used for teaching, research or publication in scientific journals.

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

I am also aware that in order 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 / /

Credit Card Payment Fees

Please note the following card surcharges will be applied:

Eftpos: 0.35%
Visa and Mastercard debit: 1%
Visa and Mastercard credit: 1%
Amex: 1.5%

The payment terminal will calculate this and display the fee before you tap or enter your PIN. Should you not wish to incur this fee, we accept cash or direct bank transfer as alternative payment options.

Please sign below to confirm your acceptance of this fee.

Signature

Print Name

Date / /