INSIGHT EYE SURGERY

New Patient Registration Form

Title: | First Name: | Surname: | Preferred Name:

Date of Birth: | Occupation:

Country of Birth: | Primary Language:

Address:

Suburb: | State: | Postcode:

Email: | Do you consent to receive email correspondence? ☐ Yes ☐ No

Home Phone: | Work Phone:

Mobile: | Do you consent to receive SMS correspondence? ☐ Yes ☐ No

Medicare No.: | Expiry Date: | Reference No.:

Private Hospital Insurance: | Membership No.:

Dept. of Veterans Affairs Card No.: | DVA Card Colour:

Are you of Aboriginal and/or Torres Strait Islander origin? ☐ Yes ☐ No

Is this a WorkCover Claim? ☐ Yes ☐ No | Claim No.:

Next of Kin Name: | Relationship to you: | Phone

Usual GP: | Clinic/Suburb:

Optometrist: | Clinic/Suburb:

Are there any additional medical specialists you would like to have copied on correspondence? Please list below:

Name | Clinic/Suburb:

Name: | Clinic/Suburb:

INSIGHT EYE SURGERY

Past Ocular History

- ☐ Cataract Surgery
- ☐ Retinal Surgery
- ☐ Age-related macular degeneration
- ☐ Diabetic eye disease
- ☐ Intravitreal injections
- ☐ Glaucoma
- ☐ Pterygium surgery
- ☐ Refractive laser surgery (laser vision correction) for short sightedness
- ☐ Refractive laser surgery (laser vision correction) for long sightedness
- ☐ Inherited retinal disease
- ☐ Contact lens wear
- ☐ Uveitis
- ☐ High Myopia
- ☐ Ocular trauma/facial trauma
- ☐ Other – please list: _____

Medical History (even if you take medication for these conditions)

- ☐ Diabetes
- ☐ Heart disease
- ☐ Hypertension (high blood pressure)
- ☐ High cholesterol
- ☐ Asthma
- ☐ Pulmonary disease
- ☐ Other – please list: _____

Family Ocular History

- ☐ Glaucoma
- ☐ Age-related macular degeneration
- ☐ Inherited retinal disease
- ☐ Blindness
- ☐ Other – please list: _____

Please list your current medications:

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Do you have any medication allergies? If so, please list below:

What is your weight in kg? ☐

What is your height in cm? ☐

INSIGHT EYE SURGERY

Privacy Consent Form

Please read this consent form carefully prior to signing.

Insight Eye Surgery 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 and treat and be proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent. Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare requirements.
- Disclosure to others involved in your health care, including treating doctors, optometrists and specialists outside this medical practice as advised by you.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.

At all times, we are required to ensure your details are treated with the confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed (including fax and email) by Insight Eye Surgery. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I give permission for my personal information to be collected, used and disclosed as described above. I also give permission for Insight Eye Surgery to request my medical history from any public and private hospitals, general practitioners or specialist surgeries to assist in my medical treatment.

I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing. I understand that I can access the full Privacy Policy for further information.

I am aware that Practice Policy requires all patients to see a Doctor for test results and whilst every effort will be made to contact patients with abnormal results, it cannot be assumed that test results are normal if there is no contact from our clinic.

I agree to pay all fees associated with my care at the time of consult.

Signed _____ Date: DD / MMM / YYYY _____

Full name: _____

If not patient signing – your name: _____

Relationship to patient: _____

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