**Patient Information**

***Private and Confidential***

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: | Click here to enter text. | | |
| Given Name: | Click here to enter text. | | |
| Title: | Choose an item. | | |
| Date of birth: | Click here to enter text. | | |
| Phone: | Mobile: Click here to enter text. | Home: Click here to enter text. | |
| Email: | Click here to enter text. | | |
| Address: | Click here to enter text. | | |
| Can we send you appointment reminders via SMS? Choose an item.  Can we send 6, 12 or 18 month recalls via email? Choose an item. | | | |
| Medicare card no: Click here to enter text. Ref no: Click here to enter text. Expiry: Click here to enter text. | | | |
| Pension / Health Care care no: Click here to enter text. Expiry: Click here to enter text. | | | |
| Veteran’s Affairs Gold Card VX no: Click here to enter text. Expiry: Click here to enter text. | | | |
| Do you have private insurance? YES  NO | | | |
| If yes, name of insurance fund: Click here to enter text. | | | |
| Membership no: Click here to enter text. Level of cover if known: Click here to enter text. | | | |
| Next of Kin: Click here to enter text. Contact Number: Click here to enter text. | | | |
| Relationship of next of kin to you: Click here to enter text. | | | |
| Optometrist Name: Click here to enter text. | | | Phone: Click here to enter text. |
| Family Doctor Name: Click here to enter text. | | | Phone: Click here to enter text. |
| Diabetic Specialist (if applicable): Click here to enter text. | | | Phone: Click here to enter text. |
|  | | | |
| IS THIS APPOINTMENT **WORKCOVER OR TAC RELATED**? YES  NO  IF YES, WE NEED DETAILS: | | | |
| Account Payer / Company Name: Click here to enter text. | | | Phone: Click here to enter text. |
| Contact person: Click here to enter text. | | | Claim no: Click here to enter text. |

***Your Eye History***

Have you had treatment from another eye specialist for any of the conditions listed below:

|  |  |
| --- | --- |
| Cataracts | Yes  No |
| Retinal Detachment | Yes  No |
| Glaucoma | Yes  No |
| Any other previous eye issues? | Yes  No |
| IF YES, PLEASE SPECIFY: Click here to enter text. | |

***Medical History***

Have you a history of any of the following?

|  |  |
| --- | --- |
| Anaemia | Yes  No |
| Arthritis | Yes  No |
| Asthma or Shortness of Breath | Yes  No |
| Bronchitis / Emphysema / Lung Disease | Yes  No |
| Blood clot on Lung / Legs | Yes  No |
| Cancer? If yes, please specify where: | Yes  No |
| Diabetes | Yes  No |
| Eczema or Dermatitis | Yes  No |
| Hay fever | Yes  No |
| Heart Disease | Yes  No |
| Hepatitis or Jaundice | Yes  No |
| High Blood Pressure | Yes  No |
| Kidney Disease | Yes  No |
| Stroke | Yes  No |
| Do you smoke, if yes, how many per day? | Yes  No |

**Current Medications** - Please mention all (including vitamin supplements)

Click here to enter text.

**Allergies**  YES  NO  Please list medication allergies and food allergies if any:

Click here to enter text.