# Patient Registration Form

**(Please complete in Black Pen Only)**

ROCKHAMPTON EYE CLINIC

**By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**
**I certify that I have read or had read to me the Initial Appointment Brochure provided by Rockhampton Eye Clinic and understand the costs & procedures involved and agree to proceed with initial and subsequent consultations. I also understand that all tests and measurements are non-refundable. I understand that this practice is NOT a Bulk Billing Practice and I am responsible for full payment for all services rendered on the day of my appointment and that if I am an Inpatient at the Mater Hospital I am responsible for full payment of all services rendered on the day of my appointment. I also understand that if a third party (eg. Rockhampton Hospital, Work cover) is covering the cost of my consultation and they refuse to pay that I will be responsible for the full cost of all services rendered on the day of my appointment.**
**I authorise this practice to release any of my personal/medical information (released via fax, post, email, medical-objects & Oculo) including the diagnosis, and the records of any treatment or examination to any required professionals or institutions including my GP and Optometrist as seen fit by my treating specialist. A copy of REC's patient privacy policy is available to be viewed at the reception desk on request. I understand that a new referral is required every 12 months (3 months for referrals from specialists). It is my responsibility to ensure that my current referral will be valid for my appointment. If your referral is expired, the Dr's at Rockhampton Eye Clinic will not be able to see you until a valid referral is provided.**

_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
| **Heart Problems** | | | |
| **Blood Clots** | | | |
| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
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| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

- o **Facebook**
- o **Newspaper**
- o **Family or Friends**
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Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

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- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
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- ☐ Tobrex
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- ☐ Other _____

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| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
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**Where did you hear about our clinic?**

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|---|---|---|---|
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| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
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Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
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- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
| **Heart Problems** | | | |
| **Blood Clots** | | | |
| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
| **Bleeding or bruising disorder** | | | **INR Level_____** |
| **Epilepsy or convulsions** | | | |
| **Cognitive Impairment** | | | |
| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

- o **Facebook**
- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
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# Patient Registration Form

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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

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**Next of Kin/Emergency Contact:**

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
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**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

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**List of any other current Medication including and Blood Thinners:**

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|---|---|---|---|
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| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Thyroid Problems** | | | |
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| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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- o **Family or Friends**
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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

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Please select from the following which best describes your cover of insurance:
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**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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**List of any other current Medication including and Blood Thinners:**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Veteran's Affairs No: _____ Expiry Date: _____

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- ☐ Lubricants
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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
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- ☐ Xalatan
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- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
| **Heart Problems** | | | |
| **Blood Clots** | | | |
| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
| **Bleeding or bruising disorder** | | | **INR Level_____** |
| **Epilepsy or convulsions** | | | |
| **Cognitive Impairment** | | | |
| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

- o **Facebook**
- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
- o **Other:_____**

# Patient Registration Form

**(Please complete in Black Pen Only)**

ROCKHAMPTON EYE CLINIC

**By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**
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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
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- ☐ Azopt
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- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
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- ☐ Acular
- ☐ Tobrex
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**List of any other current Medication including and Blood Thinners:**

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|---|---|---|---|
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| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

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Contact Name: _____Relationship: _____

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

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Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
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- ☐ Azopt
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- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Title: _____

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Medicare Number: _____ Ref No# _____ Expiry Date:_____

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Veteran's Affairs No: _____ Expiry Date: _____

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**PLEASE TURN OVER Page 1/2**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
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Veteran's Affairs No: _____ Expiry Date: _____

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**PLEASE TURN OVER Page 1/2**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
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|---|---|---|---|
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_____
_____

**Where did you hear about our clinic?**

- o **Facebook**
- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
- o **Other:_____**

# Patient Registration Form

**(Please complete in Black Pen Only)**

ROCKHAMPTON EYE CLINIC

**By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**
**I certify that I have read or had read to me the Initial Appointment Brochure provided by Rockhampton Eye Clinic and understand the costs & procedures involved and agree to proceed with initial and subsequent consultations. I also understand that all tests and measurements are non-refundable. I understand that this practice is NOT a Bulk Billing Practice and I am responsible for full payment for all services rendered on the day of my appointment and that if I am an Inpatient at the Mater Hospital I am responsible for full payment of all services rendered on the day of my appointment. I also understand that if a third party (eg. Rockhampton Hospital, Work cover) is covering the cost of my consultation and they refuse to pay that I will be responsible for the full cost of all services rendered on the day of my appointment.**
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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
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| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
| **Bleeding or bruising disorder** | | | **INR Level_____** |
| **Epilepsy or convulsions** | | | |
| **Cognitive Impairment** | | | |
| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Medicare Number: _____ Ref No# _____ Expiry Date:_____

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**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

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- ☐ Betoptic
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- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
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- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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|---|---|---|---|
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| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

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Home Phone: _____ Work Phone: _____ Mobile: _____

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**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
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- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
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- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
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| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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- o **Family or Friends**
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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

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Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

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- ☐ Combigan
- ☐ Maxidex
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**List of any other current Medication including and Blood Thinners:**

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|---|---|---|---|
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| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Medicare Number: _____ Ref No# _____ Expiry Date:_____

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Veteran's Affairs No: _____ Expiry Date: _____

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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

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| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
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Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
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- ☐ Betagon
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- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
| **Heart Problems** | | | |
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| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
| **Bleeding or bruising disorder** | | | **INR Level_____** |
| **Epilepsy or convulsions** | | | |
| **Cognitive Impairment** | | | |
| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
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# Patient Registration Form

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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
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Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

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**List of any other current Medication including and Blood Thinners:**

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|---|---|---|---|
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| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Thyroid Problems** | | | |
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| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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- o **Family or Friends**
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_____ _____

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Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

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Please select from the following which best describes your cover of insurance:
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**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
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| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Veteran's Affairs No: _____ Expiry Date: _____

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- ☐ Lubricants
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|---|---|---|---|
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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
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- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
| **Heart Problems** | | | |
| **Blood Clots** | | | |
| **Uncontrolled Asthma** | | | |
| **Thyroid Problems** | | | |
| **Bleeding or bruising disorder** | | | **INR Level_____** |
| **Epilepsy or convulsions** | | | |
| **Cognitive Impairment** | | | |
| **Rheumatic Fever** | | | |
| **Stroke TIA Fainting attack** | | | |
| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

- o **Facebook**
- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
- o **Other:_____**

# Patient Registration Form

**(Please complete in Black Pen Only)**

ROCKHAMPTON EYE CLINIC

**By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**
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_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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| | NO | YES | |
|---|---|---|---|
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| **Sleep Apnoea** | | | |
| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Title: _____

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Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

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**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

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Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
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_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
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- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
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- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

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| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
_____
_____

**Where did you hear about our clinic?**

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Veteran's Affairs No: _____ Expiry Date: _____

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**PLEASE TURN OVER Page 1/2**

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|---|---|---|---|
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| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

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**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
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|---|---|---|---|
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**Where did you hear about our clinic?**

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- o **Newspaper**
- o **Family or Friends**
- o **GP**
- o **Optometrist**
- o **Radio**
- o **Mater Hospital**
- o **Hillcrest Hospital**
- o **Rockhampton Base Hospital**
- o **Other:_____**

# Patient Registration Form

**(Please complete in Black Pen Only)**

ROCKHAMPTON EYE CLINIC

**By signing this form, I certify that I have read and answered all the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**
**I certify that I have read or had read to me the Initial Appointment Brochure provided by Rockhampton Eye Clinic and understand the costs & procedures involved and agree to proceed with initial and subsequent consultations. I also understand that all tests and measurements are non-refundable. I understand that this practice is NOT a Bulk Billing Practice and I am responsible for full payment for all services rendered on the day of my appointment and that if I am an Inpatient at the Mater Hospital I am responsible for full payment of all services rendered on the day of my appointment. I also understand that if a third party (eg. Rockhampton Hospital, Work cover) is covering the cost of my consultation and they refuse to pay that I will be responsible for the full cost of all services rendered on the day of my appointment.**
**I authorise this practice to release any of my personal/medical information (released via fax, post, email, medical-objects & Oculo) including the diagnosis, and the records of any treatment or examination to any required professionals or institutions including my GP and Optometrist as seen fit by my treating specialist. A copy of REC's patient privacy policy is available to be viewed at the reception desk on request. I understand that a new referral is required every 12 months (3 months for referrals from specialists). It is my responsibility to ensure that my current referral will be valid for my appointment. If your referral is expired, the Dr's at Rockhampton Eye Clinic will not be able to see you until a valid referral is provided.**

_____ _____

**SIGNATURE:** **DATE:**

Title: _____

First Name: _____ Middle Name:_____ Last Name: _____

Prefer Name: _____ Date of Birth: _____ Marital Status: _____

Street Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

**Next of Kin/Emergency Contact:**

Contact Name: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

**GP Name: _____Location:_____**

**Optometrist Name: _____Location:_____**

**Insurance Information:**

Medicare Number: _____ Ref No# _____ Expiry Date:_____

Aged Pension Card:_____ Expiry Date: _____

Private Health Provider Name: _____ Membership No#_____

Please select from the following which best describes your cover of insurance:
☐ Gold Hospital ☐ Silver Hospital ☐ Bronze Hospital ☐ Other: _____

**Department of Veterans Affairs:**

Veteran's Affairs No: _____ Expiry Date: _____

Do you have a: GOLD DVA CARD WHITE DVA CARD ORANGE DVA CARD

**PLEASE TURN OVER Page 1/2**

**Please write below in your own words, what you think is wrong with your eyes and what you have been referred to Rockhampton Eye clinic:**_____
_____
_____

**Have you had any previous Eye Surgery:** _____

**Which specialist did the surgery:** _____

**Medication: If you are using any current eye medication, please select from the following list:**

- ☐ Chloromycetin (Chlorsig)
- ☐ Prednefrin Forte
- ☐ Azopt
- ☐ Duotrav
- ☐ Timoptol
- ☐ Xalacom
- ☐ Trusopt
- ☐ Ocuflox
- ☐ Betagon
- ☐ Zovirx
- ☐ Betoptic
- ☐ Homatrophine
- ☐ Alphagan
- ☐ Combigan
- ☐ Maxidex
- ☐ FML
- ☐ Lumigan
- ☐ Travatan
- ☐ Xalatan
- ☐ Acular
- ☐ Tobrex
- ☐ Lubricants
- ☐ Other _____

**List of any other current Medication including and Blood Thinners:**

**PLEASE CONTACT YOUR GP AND REQUEST A COPY OF YOUR CURRENT MEDICATION LIST TO BE FAXED TO: 07 4931 3573**

**Relevant Medical Conditions (Please tick the correct columns below):-**

| | NO | YES | |
|---|---|---|---|
| **High Blood Pressure** | | | |
| **Diabetes**<br>**Do you know your sugar levels?** | | | **Type 1 ☐ or Type 2 ☐**<br>**HBA1C Levels (6monthly)_____** |
| **Rheumatoid Arthritis** | | | |
| **Renal (Kidney) Failure** | | | |
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| **Chronic bronchitis emphysema** | | | |
| **Hepatitis C, Hepatitis B, HIV** | | | **If yes, which one? _____** |
| **Heartburn or acid reflux** | | | |
| **Smokers Status** | | | **If yes, how many cigarettes per day _____** |
| **Other:** | | | |

**Do you have allergies? Please tick** o **Yes** o **No**
If so, please list:
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