BEST PRACTICE EYECARE

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Comprehensive Ophthalmologist
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Provider No: 5683412A

New Patient Registration and Release of Information Authority Form

Patient Details

Name: ..... Date of Birth: .....

Address: .....

Phone#: Home:..... Mobile: .....

Email: .....

Do you identify as Aboriginal and/or Torres Strait Islander? ☐ Yes ☐ No

Occupation: ..... If retired, previous occupation:.....

Would you like to receive a reminder via text message for future appointments? ☐ Yes ☐ No

Next of Kin Contact : ..... Ph#: .....

Relationship.....

Referrer/Practitioners Details

Your G.P.: Dr.....at.....Clinic

Your Optometrist: (if applicable) .....at..... Address

Any other specialists:(if applicable) .....at..... Address

Medical History

Allergies: .....

Past/Present Medical Problems (Please tick ✓):

☐ Diabetes
☐ Heart Disease
☐ Hypertension
☐ Asthma
☐ Hepatitis
☐ Other: .....

Past/Present Eye Problems (Please tick ✓):

☐ Glaucoma
☐ Cataract
☐ Eye Injury
☐ Squint Surgery
☐ Other Eye Surgery: .....

Current Medications/ Eye Drops:

.....

How did you hear about us? (Please tick ✓):

☐ GP / Optometrist
☐ Google
☐ Word of mouth
☐ Magazine
☐ Other: .....
☐ Radio

I consent to the use of my personal health information by Best Practice Eyecare and the disclosure of my personal health information to other health professionals to assist with my continuing care.

Signed: ..... Date: .....