INSIGHT EYE SURGERY

Title: First Name: Surname:

Preferred Name:

Address:

Suburb: State: Postcode:

Date of Birth: Occupation:

Country of Birth: Primary Language:

Home Phone: Work Phone: Mobile:

Next of Kin Name: Relationship to you: Phone:

Medicare No.: Expiry Date: Ref No.:

Private Hospital Insurance: Membership No.:

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

Pension No.: Expiry Date:

Usual GP: Suburb:

Optometrist: Suburb:

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

Name: Clinic/Suburb:

Name: Clinic/Suburb:

Name: Clinic/Suburb:

Are you a diabetic?

☐ Yes ☐ No

Do you have any allergies? (if yes, please list)

☐ Yes ☐ No

Are you currently taking any medications? (if yes, please list)

☐ Yes ☐ No

BRISBANE: Suite 203, Westside Private Hospital | 32 Morrow Street, Taringa QLD 4068 Australia | **E**: info@insighteyesurgery.com.au
NOOSA: Suite 4, Noosa Hospital | 111 Goodchap Street, Noosaville QLD 4566 Australia | **E**: noosa@insighteyesurgery.com.au
T: 07 3154 1515 | **FAX**: 07 3154 1516 | **WEBSITE**: www.insighteyesurgery.com.au

INSIGHT EYE SURGERY

Consent to Receive Correspondence

Insight Eye Surgery is able to send you appointment details and medical information via SMS/email.

We would like to advise that electronic correspondence is not a secure form of communication.

I consent to receive SMS correspondence ☐ Yes ☐ No Mobile _____

I consent to receive email correspondence ☐ Yes ☐ No Email _____

Collection of Patient Information

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors, optometrists and specialists outside this medical practice as advised by you.

Consent to Collect Patient Information

I understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any purpose other than the above, my consent will be sought. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signed _____ Date: / /

Full Name: _____

BRISBANE: Suite 203, Westside Private Hospital | 32 Morrow Street, Taringa QLD 4068 Australia | **E**: info@insighteyesurgery.com.au
NOOSA: Suite 4, Noosa Hospital | 111 Goodchap Street, Noosaville QLD 4566 Australia | **E**: noosa@insighteyesurgery.com.au
T: 07 3154 1515 | **FAX**: 07 3154 1516 | **WEBSITE**: www.insighteyesurgery.com.au