PATIENT INFORMATION FORM

FRANKSTON EYE & LASER CENTRE

Please complete this form prior to your initial visit if possible and bring to your appointment

☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr Date of Birth: ____/____/____

First name: _____ Last name: _____

Phone: Mobile:_____ Home:_____ Work:_____

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

Email Address: _____Occupation: _____

MEDICARE NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐

Exp. date: _____/_____ Reference No next to your name:_____

Private Health Insurance: ☐Yes ☐No Fund Name: _____

Name of Insured: _____Member no:_____

Pension/Health Care Card: ☐☐☐ ☐☐☐ ☐☐☐☐ Expires: ____/____

Veterans Affairs (DVA) No:_____ Gold / White Expires: ____/____

Workcover/TAC claim: ☐Yes ☐No

EMERGENCY CONTACT: Name: _____

Contact number: _____Relationship to you: _____

YOUR OPTOMETRIST: Name of optometrist: _____

Clinic address: _____

YOUR GP (family doctor): Name: _____

Practice Name & address: _____

AGREEMENT

- I am directly responsible for all charges incurred.
- I authorise the release of any medical information to insurance companies as may be needed to process my claim.
- I authorise the use of fax or email for sending and receiving relevant medical reports/records if required.

Signed: _____ Date: ____/____/____