

## Patient Registration

Title	Surname	First Name
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Address
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Suburb	State	Postcode
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Telephone	(H)	(W)	(M)
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Email
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Date of Birth	DD / MM / YYYY	Occupation
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<b>Family Doctor</b>
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Address
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Suburb	State	Postcode
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<b>Optometrist</b>
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Address
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Suburb	State	Postcode
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### How did you hear about Central Sydney Eye Surgeons?

Optometrist  GP  Other specialist  Relatives/Friends  Internet/Website  Yellow/White Pages  Other

### Are you covered by (please tick if yes)

<input type="checkbox"/> Centrelink Pensioner Card	<input type="checkbox"/> Centrelink Health Care Card	<input type="checkbox"/> Dept. of Veterans Affairs	<input type="checkbox"/> None of the above
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Do you have Private Health Insurance?	<input type="checkbox"/> NO	<input type="checkbox"/> YES If yes, Name of Fund
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Medicare Number	Expiry Date	MM / YYYY	Reference No
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### Privacy Information and Consent Form

The law gives you certain privacy rights in relation to information that you give to this medical practice. We require your consent to collect personal information about you. The fact that you have come here implies that you consent to the doctor knowing about your health situation either for a particular event or generally. Please carefully read the following information about privacy issues then sign this form where indicated below. The main reason we collect information from you is so we can assess, diagnose and treat your illnesses properly, liaise with your other doctors and be pro-active in your health care. We will also use the information you provide in the following ways, administration of this medical practice, billing, including compliance with Medicare and Health Insurance Commission requirements

I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.

Signature	Date	DD / MM / YYYY
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