Central Sydney
Eye Surgeons

Suite G8, RPAH Medical Centre,
100 Carillon Avenue,
Newtown, NSW 2042

P (02) 95193882 | F (02) 95502839
E reception@centralsydneyeye.com.au
www.centralsydneyeye.com.au

# Patient Registration Form

Please complete this form and present it to our receptionists on arrival. The information in this questionnaire is confidential.

## PATIENT DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Prof *Name must be the same as Medicare Card*

Surname ..... Middle Name ..... First Name .....

Preferred Name ..... DOB ..... Occupation .....

Address ..... Suburb ..... Post Code .....

Preferred Phone ..... Email .....

Next of Kin/ Contact person in Emergency ..... .....

Relationship ..... Phone .....

Are you on a government pension? ☐ Yes ☐ No Do you have a Medicare Card? ☐ Yes ☐ No

## MEDICAL PROVIDERS

Optometrist..... GP.....

Address..... Address.....

..... .....

**Are any other doctors involved in your care eg. Endocrinologist?**

Specialist Name..... Specialist Name.....

Address..... Address.....

..... .....

## PRIVATE HEALTH INSURANCE

Health Fund .....

Membership Number .....

## HOW DID YOU HEAR ABOUT US?

◯ Optometrist ◯ Specialist ◯ Yellow Pages

◯ GP ◯ Internet ◯ Relatives/Friend

## IF PATIENT IS UNDER 18 YEARS OLD

**Person responsible for account to complete**

Name ..... Relationship ..... DOB .....

We will send you emails and SMS messages regarding your appointments with us. ☐ I agree to receiving emails & SMS

☐ By ticking this box I agree to the above

Date.....

This medical practice collects information from you for the primary purpose of providing quality health care. This information is used for administrative purposes, disclosure to others involved in your health care & for referral to other doctors or medical tests. This practice has a privacy policy on handling patient information.
I have been informed of the costs involved & understand that payment of the account is my responsibility.
I am also aware that in order for me to claim a Medicare rebate I will need to provide a valid referral to my doctor.

Central Sydney
Eye Surgeons

Suite G8, RPAH Medical Centre,
100 Carillon Avenue,
Newtown, NSW 2042

P (02) 95193882 | F (02) 95502839
E reception@centralsydneyeye.com.au
www.centralsydneyeye.com.au

# Health Questionnaire

Please fill in as much information as possible on this form prior to your consultation.

FULL NAME ..... EMAIL .....

## GENERAL HEALTH Do you have any of the following conditions?

- ☐ Asthma
- ☐ High cholesterol
- ☐ Hypertension *(high blood pressure)*
- ☐ Heart disease
- ☐ Stroke If yes, when? .....

☐ Diabetes *( please provide details)*

Diagnosed: ...../...../.....

Most recent HbA1c

Home **BSL** *( blood sugar level)*

..... .....

Result ..... Range .....

☐ Type 1 ☐ Type 2 ☐ Borderline/diet control ☐ On Insulin

## MEDICATION Please list your current medications (including any naturopathic/ herbal medicine).

..... ..... .....

..... ..... .....

## ALLERGIES Please provide details of any allergies you have to medication

| Medication | Reaction |
|---|---|
| ..... | ..... |
| ..... | ..... |

## FAMILY HISTORY Is there a family history of any of the following conditions and if yes, who?

- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Diabetic eye disease

Family member with condition

.....

## EYE HISTORY Have you ever had any of the following to your eyes?

**☐ Surgery**

What surgery did you have?

.....

Which eye was operated on?

◯ Left ◯ Right

Who did the surgery?

.....

When .....

**☐ Laser**

List procedure/condition?

.....

Which eye had the laser?

◯ Left ◯ Right

Who did the laser?

.....

When .....

**☐ Trauma**

What happened?

.....

Which eye was involved?

◯ Left ◯ Right

Describe treatment if any?

.....

When .....

**☐ Patching**

How old were you?

.....

Which eye was involved?

◯ Left ◯ Right

Length of time patching?

.....