DONCASTER EYE CENTRE - NEW PATIENT REGISTRATION FORM

As a full eye examination requires pupil dilation, your vision maybe blurry for a few hours following the examination. We advise you do not drive until your vision is back to normal.

Waiting times: We suggest that you allow 1-2 hours for your appointment as delays can occur.

Patient Details

Family Name……. Given Names…… Title…….

Date of Birth…….....

Address……..

Postal Address (if not as above)…….....

Ph: Hm…….. Work…… Mobile…….....

Medicare Card number _ _ _ _ _ _ _ _ _ __ **Number next to your name** ___ **Expiry Date** ____/_____

Pension or Health Care Card Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Expiry Date** _____

Health Fund Hospital Cover (we do not need your extras cover information) Fund _____

Health fund number _____ **Number next to your name** _____

Would you like SMS reminders about your upcoming appointments? YES ☐ *NO* ☐

Name of person responsible for payment (if not patient)

…….....

Next of Kin (Emergency Contact)

Name……..…… (Relationship)…..... Ph…….

Name & Address of Family Doctor (if not the referring practitioner)…….....

…….....

- **Fees are payable on the day of our consultation and we will submit this claim on behalf of Medicare for you.**
- **Any other treatment or tests will attract additional fees. Please check with reception if you require further information regarding the fees.**
- **I also agree to meet the cost of my medical treatment.**

Signature……..Date……..

Please continue over page…

If this consultation is regarding **Worker's Compensation** or the **Transport Accident Commission** please indicate below and we will ask for more details at the front desk

Worker's Compensation ☐ **Transport Accident Commission TAC** ☐

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Privacy Policy:

Your privacy is a priority to us. Protecting your privacy is part of our service.
Your personal information which we hold is available to you on request under Health Records Act 2001 (Vic) and/or the Privacy Act 1988 (Cth).

When you become a patient of our practice, so that we may provide services to you, we require you to provide us with your personal information and your relevant medical history. Your personal information is used for billing and receipting purposes and to assist in providing assessment, diagnosis and treatment of your ophthalmological needs.

As part of our privacy policy we ensure your personal information (including health information) are private and confidential and will be stored and treated as such. Your personal information can only be accessed by authorized staff. In some cases, your information may need to be disclosed to other health professionals to determine the best possible outcome and treatment that is right for you.

Please advise us of any changes to your personal information so that we are able to accurately maintain your record.

Medical Records
All patient information is private and confidential. It will not to be disclosed to family, friends, or others without the patient's consent, unless necessary to provide medical services to you, or as legally directed.

You can obtain your medical records held by us by submitting a written and signed request.

Procedure
Medical records and other health information is stored securely and is not able to be viewed or accessed by the public.

Disposal

We will store your medical record for the period prescribed by the Health Records Act 2001 (Vic). After this time, medical records are destroyed in a secure manner by shredding, or use of an accredited secure document disposal company.

Correspondence
If you request personal information to be emailed, it is important that you understand that it is unencrypted and therefore not secure.

Computerised Records
Specific systems have been put in place to protect the privacy, security and integrity of your personal information.

Disclosure:
We will never disclose your personal information without your consent, with the exception of police request or subpoena by a court of law.

Complaints:
If you are in any way dissatisfied with the way in which we have handled or propose to handle your personal information, you may lodge a complaint with our practice manager (in writing) at reception@doncastereyecentre.com.au. All complaints will be responded to in a timely manner.

Agreement & Consent:
By signing this document, you understand our practice policy and the information outlined above and consent to disclosure of your information to a 3rd party (eg other health professionals), only when considered beneficial to your medical treatment.

Signed _____ Date _____