Southern Eye Centre Day Surgery

www.southerneye.com.au

44 Cranbourne Road, Frankston 3199 Ph: (03) 9783 5245 Fax: (03) 9783 9882 Email: info@southerneye.com.au ABN: 96 006 650 264

Patient Registration Form

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Date of Birth:______/_____/______

First name:______________________ Last name: ______________________

Phone: Mobile: ______________ Home:____________ Work:______________

Home Address: ____

Suburb:______________ State:______________ Postcode:______________

Postal Address (if different from above):______________________________

Suburb:______________ State:______________ Postcode:______________

Email Address: ______________________________ Occupation:______________

Aboriginal or Torres Strait Islander________________________________

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:______/______/______