PATIENT REGISTRATION FORM

Section A: Personal Details

Title | **First Name(s)** | **Surname**

Preferred Name | **Date of Birth** | **Gender**

Home Address | **Postcode**

Postal Address *(As Above if not needed)* | **Postcode**

Home Phone | **Work Phone** | **Mobile Phone**

Email Address | **Occupation**

Section B: Healthcare Details

Medicare Card Number | **Ref No.** | **Medicare Card Expiry**

Do you hold a Reciprocal Medicare Card? If Yes, please state what Country.

NO MEDICARE ☐

DVA Card Number | **DVA Card Type** Gold ◯ White ◯ Orange ◯ | **DVA Card Expiry**

Pension Card Number | **Pension Card Expiry**

Do you require Interpreting Services? If so what language/ service is needed?

Private Health Insurance

Health Fund Name | **Policy Number** | **Hospital Cover** Yes ◯ No ◯ | **Extras Cover** Yes ◯ No ◯

Section C: Emergency Contacts

1. Contact Name | **Contact Phone** | **Relationship to you**

Section D: Release of Information

I authorise the following person/s to speak to the Queensland Eye Institute on my behalf, pertaining to my medical information, appointments, account enquiries and billing.

1. Contact Name | **Contact Phone** | **Relationship to you**

Section E: Healthcare Providers

General Practitioner Name:

Practice Name

Practice Address

Optometrist Name:

Clinic Name

Clinic Address

Other Provider *(Other specialists/ health professionals you wish to receive medical correspondence regarding your healthcare, please list below)*

Provider Name

Provider Specialty

Provider Practice Location

Section F: Authorisation & Consent

In accordance with the privacy guidelines and Privacy Act we are required to ask for your consent to collect and store information about you. I hereby give consent and agree for my personal information to be used by and for:

· Administrative purposes in running our medical practice and regarding your health care and management.
· Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
· Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice.
· Email is considered unsecure, unencrypted method of communication and you agree not to hold the Queensland Eye Institute responsible for the risks associated with email use including, but not limited to, security breaches and improper disclosure of confidential information.

Appointment Reminders: *I would like to receive an SMS text message for any future appointments.* **Yes** ◯ **No** ◯

Emailing: *I understand and request that email be used to transmit my required medical information.* **Yes** ◯ **No** ◯

QEI Questionnaire Consent:

QEI Foundation	*I consent to my personal details being provided to the Queensland Eye Institute Foundation which helps raise vital funds for research, education and clinical care to further eye health and disease research.*	**Yes** ◯ **No** ◯
Research/ Audit	*I consent to the collection and retention of information about my medical condition and treatment for research purposes in accordance with the Commonwealth Privacy Act Section 95A (1988). I understand that my information will be kept confidential and my details will remain anonymous.*	**Yes** ◯ **No** ◯
Teaching	*I consent to have a medical/optometry Student, Optometrist, Registrar or other medical practitioner present in the room during my consultation.*	**Yes** ◯ **No** ◯
Video/Audio recording	*I consent to photographic, video/audio recording of my history, condition, treatment or progress and acknowledge that this information may be used for clinical, educational, scientific or research purposes. I understand that this material will remain the property of the Queensland Eye Institute.*	**Yes** ◯ **No** ◯

Section G: Patient Signature

Patient Signature:		**Date:**	
Guardian Signature:		**Guardian Name:**	

Please complete and return to: Reception@qei.org.au