Patient Information Form	Eye Associates

SURNAME: Mr / Mrs / Miss / Ms _____

FIRST NAME _____ DATE OF BIRTH: _____

HOME ADDRESS: _____POST CODE: _____

HOME NUMBER: _____ WORK NUMBER: _____

MOBILE: _____ EMAIL: _____

OCCUPATION: _____

NAME OF EMPLOYER (if WorkCover) _____

MEDICARE NUMBER: _____ (Ref:___) EXPIRES: _____

PENSION / DVA NUMBER:_____

NAME OF HEALTH FUND: _____ MEMBER NO: _____

FULL NAME AND ADDRESS OF PERSON TO BE BILLED: (If same as PATIENT please write "**as above**")

_____

_____ TELEPHONE NO: _____

REFERRED BY: _____

FAMILY DOCTOR'SNAME:_____ PHONE NUMBER:_____

ADDRESS:_____

IN CASE OF EMERGENCY:

CONTACT NAME: _____

RELATIONSHIP:_____

ADDRESS: _____

HOME NUMBER: _____ MOBILE NUMBER: _____

EMAIL: _____

Please continue on back page

PLEASE ANSWER THESE QUESTIONS:

Reason for attending _____

Have you had trouble with your eyes in the past? NO / YES Please specify

_____
(e.g. infections, injuries, operations)

Is there a history of eye trouble in your family? NO / YES If so, Please Specify in whom, and what?

Do you wear glasses/contact lenses? NO / YES. If YES, how old are your glasses/contact lenses?

_____
(cataracts, glaucoma, turned eyes, retinal detachment)

Are you allergic to any medications? NO / YES If so, Please specify

_____

Do you have any general ailments? NO / YES If so, Please specify

_____

What medications, if any, are you taking? Please specify

_____

_____

_____

_____

Do you smoke? NO / YES / EX . If EX smoker, how many days/years since you have quit?

_____

What operations, if any, have you had? Please specify:

HOW DID YOU HEAR ABOUT EYE ASSOCIATES? (*Please circle one only*):

Friend / Relative / Neighbour / Doctor / Optometrist/ Private Hospital / Public Hospital / Insurance Company / Work Colleague /White Pages / Yellow Pages / Website / Ophthalmologist / Other Specialist / Media