Central Sydney Eye Surgeons

Please complete all questions

PATIENT INFORMATION

Title ____ First Name ____ Last Name ____

Address ____

Suburb ____ State ____ Postcode ____

Date of Birth ____ / ____ / ____ Sex: ☐ Male ☐ Female ☐ Other

Day Time Phone ____ After Hours Phone ____

Email address ____ Occupation ____

Emergency Contact ____ Relationship ____ Contact number ____

Do you require an interpreter? ☐ Yes No ☐ ____

IF THE PATIENT IS A MINOR

Please complete if patient is 17 years or younger

Mother Full Name ____ Mother Contact ____

Mother Address ____

Father Full Name ____ Father Contact ____

Father Address ____

MEDICAL REFERRER INFORMATION

Referring Doctor Name ____

Are there any other medical practitioners (including your regular GP) you would like to have copied on your correspondence apart from your referring doctor? Please list below

Name ____ Address ____ Phone ____

Name ____ Address ____ Phone ____

Optometrist ____

Address ____

HOW DID YOU FIND OUT ABOUT THIS CLINIC? (please select most applicable)

- ☐ Relative
- ☐ Friend
- ☐ GP
- ☐ Specialist
- ☐ Website
- ☐ Internet Search
- ☐ Advertising
- ☐ Other

PRIVACY CONSENT AND INFORMATION

Central Sydney Eye Surgeons takes our patient's privacy seriously. We comply with The Privacy Act 1988 – for further information please visit https://www.oaic.gov.au/privacy-law/privacy-act/

Central Sydney Eye Surgeons requires your consent to collect, use, and disclose information about you for the primary purpose of providing quality health care. Central Sydney Eye Surgeons stores your information digitally on a secure firewall protected server. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise you on all your health care needs.

Please read the following carefully before signing. We encourage you to ask questions or seek clarification if needed.

By ticking the box below and printing your name (as a patient or guardian of a patient), you acknowledge the following:

- ☐ I give consent for my personal health information to be used for administrative purposes to assist in the running of Central Sydney Eye Surgeons in the coordination of my care, including disclosure to others involved in my healthcare such as referring doctors, treating doctors/specialists, allied health services and diagnostic service providers within and outside of Central Sydney Eye Surgeons.
- ☐ I give consent to be part of Central Sydney Eye Surgeons's appointment reminders and notifications.
- ☐ I have read and understand the above information. I understand I am free to withdraw my consent at any time by contacting Central Sydney Eye Surgeons.

Thank you for completing this form. Please sign or initial below.

Signature ____________________ Date ____________________

Name of Parent/Guardian/Carer (if patient under 18 years of age)

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Once completed, please save this form with your full name as the file name, and email to reception@centralsydneyeye.com.au or fax to (02) 9550 2839