waverleyeyeclinic

# Patient Registration Form

## Patient Details:

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr ◯ Others:

First Name

Last Name

Preferred Name

Date of Birth

## Patient Contact Details:

Home Phone

Mobile

Home Address

Postcode

City / Suburb

State

Postal Address (If different to home address)

Postcode

City / Suburb

State

## Emergency Contact Details:

Name

Relationship to Patient

Address

Postcode

City / Suburb

State

Email

Mobile

## Next of Kin Contact Details:

Name

Relationship to Patient

Address

Postcode

City / Suburb

State

Email

Mobile

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## Referring Doctor to Us:

Referring Doctor's Name

Contact Number

Address

## Medicare:

Medicare Card Number

Ref

## Private Health Insurance:

Provider

Membership Number

## Pension / DVA Gold Card:

Pension Number

DVA Card Number

## Work-cover / TAC Related:

Work-cover related

☐ Select if Applicable

TAC Related

☐ Select if Applicable

## Pension / DVA Gold Card:

Pension Number

DVA Card Number

## Privacy:

Please specify who we can discuss your personal/health care details with
(DO NOT include medical Professionals)

☐ Please select if unrestricted

**OR**

Please specify individuals below:

Name

Name

Name

Name

Name

Name