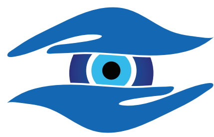


SPECIALIST
EYE SURGEONS

1/38 Margaret Street, Moonee Ponds, VIC 3039
Phone (03) 9372 7022 | Fax (03) 9372 7044
E: contact@specialisteyesurgeons.com.au
W: specialisteyesurgeons.com.au

Confidential Patient Registration

Personal Information

Title (circle) : Mr Mrs Ms Miss Mast AND Dr Prof Other:

Surname : ______________________ Given Name: ______________________ DOB: __________

Address: ______________________ Suburb: __________________ Postcode: ____________

Phone: Home: ________________ Work: ________________ Mobile: ________________

Medicare Details

Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Number next to name: ____ Exp: ____/________

Next of Kin/ Emergency Contact

Full Name: __________________ Relation: ______________ Contact Number: ______________

I give permission for my next of kin to enquire/obtain private medical information (circle): YES NO

I also nominate the following person(s) to enquire on my behalf:______________________________

Written consent will be required at any point should you decide to change who has access to your information.

Private Health Insurance

Fund Name: __________________ Membership Number: ______________________

GP Details

DR: ________________________ Clinic Name: ________________________________

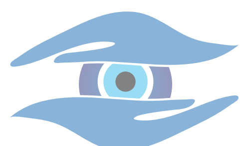
Phone: __________________ Address: ____

Optometrist Details

Name: ________________________ Business Name: ________________________________

Phone: __________________ Address: ____

Please Turn Over >>>



Consultation Fees

Non-Concession	(Under 60yrs)	
Initial Consultation :	$220.00	(Rebate $73.75)
Review Consultation:	$140.00	(Rebate $37.55)

Concession	(60 and over, Disability Pensioner)	
Initial Consultation:	$170.00	(Rebate $73.75)
Review Consultation:	$110.00	(Rebate $37.55)

(If applicable:)
Disability Pension Card Number: ________________________________ Exp: _____________

(If applicable)
DVA Card Number: ________________________________ Exp: _____________

Agreement

I understand that this Practice handles personal information in accordance with the National Privacy Principles enshrined in the Commonwealth Privacy Act 1988.

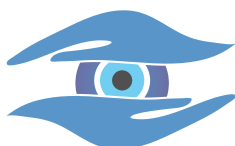
I may gain access to my medical information, or provide permission for others to do so, by contacting Specialist Eye Surgeons with a written and signed request.

I consent to the handling and sharing of my information by this Practice for the purpose of my health care, and for any associated administrative and billing purposes. I agree that photos/images may be obtained for my treatment, and for my medicare or health fund requirements.
I also consent to the use of my information (including notes, photos, tests, and images) in accordance with privacy protection guidelines, for educational, teaching, presentation, or publication purposes.

I hereby agree to pay all associated fees relating to my consultation/s, tests and/or surgery or other expenses incurred in my treatment. I acknowledge that if an account is overdue, the Practice reserves the right to refer the account to a Collection Agency. I agree to meet all costs and commissions incurred in employing the said Agency to collect the overdue account.

I have read, understood and agree to all the above.

Signature: ______________________________ Date: _______ / ________ / 20_____



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