PURE SIGHT
EYE SURGEONS

CONFIDENTIAL PATIENT INFORMATION

Contact Information

Patient File Number: _____ Date of Birth:_____/_____/_____

Title: _____ Surname: _____ Given Name: _____

Preferred Name: _____ M | F | Non Binary | Transgender | Intersex | Prefer not to say

Marital Status: Married | Single | Widowed | Divorced | Separated | Partner | Prefer not to say

IMPORTANT! Check your name (above) matches your Medicare Card. Please correct spelling if required.

Residential Address: _____

Postal Address: _____

Home Phone: _____ Mobile Phone:_____

Work Phone: _____ Other Contact:_____

Email Address: _____

Preferred method of contact: Email | Phone: Home Mobile Work | Mail

Name of next of Kin (Emergency contact): _____

Relationship to you: _____Contact No _____

Medical Information

Medicare Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ # _____ Expiry Date: _____/20_____

Private Health Fund:_____ Membership No:_____

Pension Card No:_____

Department of Veteran Affairs (DVA) Number: _____Card colour: _____

Optometrist Name: _____ Suburb: _____

G.P. Name: _____ Suburb: _____

I have come with a referral today: NO | YES - please provide your referral to reception with this form

Other Information

How did you here about us? _____

Do you consent to receiving results/clinical information via Email: YES / NO (Please circle)

Do you consent to SMS contact/reminders from the surgery: YES / NO (Please circle)

Information collected for the provision of your health care, with your consent, will be provided to your General Practitioner or any other practitioner involved in your care. By providing your signature below you will indicate that you understand the terms outlined above:

Patient signature: _____ Staff Initial: _____