2/14-16 Hurtle Parade, Mawson Lakes SA 5095
TEL: (08) 8359 5944 | FAX: (08) 8359 6766
mawsonlakes@northerneyespecialists.com

NORTHERN EYE SPECIALISTS
www.northerneyespecialists.com

43 John Rice Avenue, Elizabeth Vale SA 5112
TEL: (08) 8281 8271 | FAX: (08) 8281 0282
elizabethvale@northerneyespecialists.com

PATIENT REGISTRATION

Title: _____ First name: _____ Surname: _____

Preferred name: _____ Date of birth: _____ Gender: M / F

Address: _____

Phone number: (Home) _____ (Mobile)_____

E-mail: _____

Indigenous Status (please circle): Aboriginal Torres Strait Islander Neither

Medicare Number: _____ Ref No: _____ Medicare expiry date: _____

Private Health Insurance Provider: _____ No: _____

DVA card number: _____ DVA card colour: _____
(Department of Veteran's Affairs)

Aged/Disability Pension card number: _____ Expiry: _____

Usual doctor (GP): _____ Surgery name: _____

Usual Optometrist: _____ Location: _____

Other interested parties / Specialists to send correspondence to: _____

Parent / Legal Guardian (if applicable):

Primary account holders name: Mr/Mrs _____ Date of birth: _____

Medicare Number: _____ Ref No: _____ Medicare expiry date: _____

PLEASE TURN OVER PAGE

Department for Child Protection (if applicable):

Case workers name: _____ Office Location: _____

Phone No: _____ Email address: _____

Work Cover (if applicable):

Employer/Company name: _____

Address: _____ Phone No: _____

Workcover Insurer: _____Claim No: _____

Emergency Contact Details:

Given name: _____ Surname: _____

Telephone number: (Home)_____ (Mob)_____

Relationship (i.e. family/friend etc): _____

Confidentiality: NES follow the National Privacy Policy rules as per The Privacy Act 1988(Cth).
You are giving consent for all your information, personal and medical, to be provided to other specialists and allied health providers, which may be transferred electronically. You also provide consent for access of information for our ongoing professional, clinical, and quality assurance programs. De-identified information, investigation reports and photographs may be used for research and teaching purposes.
Complaints: Please do not hesitate to discuss any concerns or suggestions about any issues with your Doctor or any staff member. Please ask for a confidential feedback form. Your feedback is important to us to meet our patient needs.
Security: Your medical records will be stored safely and securely at all times. NES has a robust electronic data storage system with backups. Please ask for our data breach policy if you have any questions.
Fees: I agree to pay the consultation, investigation, and procedure fees in full. I permit the practitioner who rendered the services the authority to electronically lodge the Medicare claim on my behalf, and I agree to pay in full the remaining private fees for any of the services.

I permit NES staff to contact me by telephone, and if necessary, leave a message.

I have read the above Patient Privacy Information and agree to the collection and use of information regarding my care.

Signature of patient: ..... Date: .....

Signature of parent/legal guardian (if applicable): ..... Date: .....