Registration form for a NEW PATIENT. To save time, this can be completed and brought with you for your first appointment.

WELCOME TO OUR PRACTICE

Patient's Details

Patient ID: ______

Date ______

Name *(Surname, First Name)* ______ Title: Mast / Miss / ______

Known As *(if different)* ______ Birthdate *(DD-MM-YYYY)*: __ __ - __ __ - __ __ __ __

Address *(postal)*: ______ Postcode: ______

Home No.: ______ Work No.: ______ Mobile: ______ Fax No.: ______

Email: ______ *(We sometimes use email to contact our patients)* Age: ______ Sex: ☐ M ☐ F

Medicare: ______ Ref: ______ Exp: ______

Veteran's Affair Card: ☐ Gold ☐ White ☐ Orange Veterans Affairs Card No.: ______

Some Health Insurance Funds require extra information. Please advise us so that we can provide these details for you:

☐ Private Fund (Name): ______

Medical Practitioner: ______ May we send a report to your GP should there be any concerns? ☐ Yes ☐ No

Occupation: ______ Hobbies / Sports: ______

Health History *(Please answer to the following questions)*

Are you presently under a physicians care? ☐ Yes ☐ No

Have you or anyone in your family ever had: ☐ Glaucoma ☐ Macular Degeneration

Do you have or have you ever had:

☐ Allergies or Hay Fever
☐ Anemia
☐ Stroke
☐ Arthritis
☐ Double Vision
☐ Eye Surgery or Injury
☐ Abnormal Blood Pressure
☐ Serious Head Injury
☐ Frequent Headaches
☐ Abnormal Thyroid
☐ Blurry Distance Vision
☐ Blurry Near Vision
☐ Women: Are you Pregnant?

Have you ever worn contact lenses, or are you interested in them? ☐ Yes ☐ No

Is there any blindness in your family? ☐ Yes ☐ No

Are you or anyone in your family diabetic? ☐ Yes ☐ No

Have you had a recent illness? ☐ Yes ☐ No

Are you taking medication for: ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid ☐ Birth Control ☐ Other ______

Please describe your last Visual Exam ______

Approximate Date *(DD-MM-YYYY)*: __ __ - __ __ - __ __ __ __ By whom: ______

Are you interested in updating your spectacle frame? ☐ Yes ☐ No

NB: Our practice utilises security cameras in both the dispensing area as well as the consulting rooms. By completing this form, you provide consent to proceed. If you do have a concern, you are welcome to raise it with the practice manager.

What recommended you to our practice?

☐ Mailing ☐ Newspaper ☐ Radio ☐ Television ☐ Website ☐ Yellow Pages ☐ Doctor
☐ Friend ☐ School ☐ Location ☐ Reputation ☐ Other ______