Lilydale Eye Clinic Patient Registration Form

Title:{Mr Mrs Miss Ms Master Dr.} **Surname:**.....

First Name: .....**Preferred Name:** .....

Residential Address: .....

Correspondence Address: .....

Phone Home: ..... **Mobile**.....

Date of Birth: ...../...../..... **Email**.....

If patient under 18 years, parents names:.....

Date of Birth of Parent...../...../..... Position on Medicare Card ☐

(this information is to claim the Medicare rebate)

Does patient have a carer *or* limited English? Yes / No

If so, contact name & phone number:.....

MEDICARE NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐ **Position on Card** ☐

(no. on the left hand side of your name)

Do you have a Veteran's Affairs Gold Card? Yes No

VX File Number .....

Do you have a Pension, Health Care Card, or Concession Card?

If yes, please state type – (Age/Dsp/Carers) Number.....

Do you have Hospital Private Insurance? Yes No

Name of Fund.....Membership No.....Length of M'Ship.....

Usual Family Doctor

Name.....

Address.....

Optometrist Details (Where did you buy your current prescription glasses)?

Name.....

Address.....

I acknowledge that this is not a Bulk Billing practice & I am required to make full payment on the day of consultation. (Your payment will be automatically sent to Medicare for prompt rebate into your nominated bank account within 48 hours. If no bank account has been nominated, we can not claim on your behalf). Signature .....