MELBOURNE CHILDRENS EYE CLINIC - PATIENT REGISTRATION FORM

CONFIDENTIAL INFORMATION

MELBOURNE CHILDREN'S EYE CLINIC

PERSONAL INFORMATION

PATIENT SURNAME ……

PATIENT GIVEN NAME ……

DATE OF BIRTH ……../……/…….. MALE / FEMALE

ADDRESS ……

……..POSTCODE ……..

TELEPHONE NO: HOME ……..

PARENT NAME ……. AND MOBILE ……..

PARENT NAME …… AND MOBILE ……

EMAIL ADDRESS OF PARENT ……

Please confirm that you are happy to receive communication by email: YES / NO

PATIENTS MEDICARE NO …… ……..REF NO ……EXP DATE…….

TO ENABLE US TO FORWARD THE ACCOUNT TO MEDICARE FOR YOU REBATE WE REQUIRE

PARENTS NAMES AS REGISTERED WITH MEDICARE ……..

PARENT MEDICARE NO …… ……..REF NO ……EXP DATE…….

PARENT DATE OF BIRTH ……../……../……

PRIVATE HEALTH FUND ……. MEMBER NO……

REFERRING DOCTORS/OPTOMETRIST NAME ……

YOUR LOCAL GP NAME ……

ADDRESS ……

TELEPHONE ……

DOES YOUR CHILD HAVE A ROYAL CHILDRENS HOSPITAL HISTORY YES / NO

IF SO THE UR NO. IS: ……

CONTINUED OVER ……

MEDICAL HISTORY

PATIENTS BIRTH WEIGHT ……ORDER OF BIRTH EG: 1ST CHILD/2ND/ETC ……

WAS THIS PREMATURE BIRTH YES / NO BY HOW MANY WEEKS? ……

AT WHICH HOSPITAL WAS HE/SHE BORN? …….

WAS THE DELVERY NORMAL / FORCEPS / CAESAREAN

WAS HE / SHE WELL AFTER BIRTH ? YES / NO

GIVE DETAILS IF UNWELL …….

…….

LIST ANY MAJOR ILLNESS OR OPERATION SINCE BIRTH

…….

…….

FAMILY HISTORY

GIVE DETAILS OF ANY EYE DISEASE IN THE FAMILY

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PRIVACY STATEMENT

THE INFORMATION PROVIDED ON THIS FORM IS COLLECTED FOR THE PURPOSE OF PROVIDING COMPREHENSIVE HEALTH CARE. THIS INFORMATION WILL BE RETAINED ON THE PATIENT RECORD AND KEPT CONFIDENTIAL. THE PATIENTS RECORD MAY HOWEVER BE DISCLOSED TO A THIRD PARTY INVOLVED IN THE CARE AND UNDER CERTAIN CIRCUMSTANCES – WHERE REQUIRED BY LAW OR WHEN REQUESTED BY ANOTHER MEDICAL PRACTITIONER/ HOSPITAL INCLUDING EMERGENCY MEDICAL CARE

CLINICAL PHOTOGRAPHY

PHOTOGRAPHS OR VIDEOS OF YOUR CHILD MAY BE TAKEN TO RECORD CLINICAL FINDINGS. THESE WILL BE USED FOR:

1. **YOUR CHILD'S MEDICAL RECORD**
   AND MAYBE BE USED FOR:
2. **THE TEACHING OF HEALTH PROFESSIONALS AND STUDENTS STUDYING HEALTHCARE HERE AND IN OTHER HOSPITALS/COLLEGES/UNIVERSITIES**
3. **THE EDUCATION OF PATIENTS WITH CONDITIONS SIMILAR TO YOUR CHILDS**
4. **PUBLICATION IN MEDICAL AND SCIENTIFIC JOURNALS OR TEXTBOOKS. IN THIS CASE YOU WILL BE CONTACTED TO OBTAIN SPECIFIC WRITTEN PERMISSION.**

FINANCIAL CONSENT

I UNDERSTAND THAT I WILL INCUR OUT OF POCKET EXPENSES AND THAT THE FEES ARE DUE AND PAYABLE ON THE DAY OF CONSULTATION.

PLEASE SIGN TO CONFIRM YOU HAVE READ AND UNDERSTOOD THE PRIVACY STATEMENT AND FINANCIAL CONSENT

SIGNATURE ……. DATE…….