Clin Professor Stephanie L Watson

BSc(Med), MBBS, FRANZCO, PhD

Patient registration details

Title _____ First Names _____ Last Name _____

DOB _____ Home Phone _____ Work Phone _____

Mobile Phone _____ ☐ Opt out of SMS Appointment reminders

Physical Address _____

Email address _____ Occupation _____

Next of kin _____ Phone _____

Family Doctor _____ Address _____

Optometrist _____ Address _____

- Private Health Insurance Fund Name _____ membership number/UPI _____
- Medicare __ __ __ __ / __ __ __ __ __ / __ Ref ___ Expiry __ / _____
- Veterans Card Number _____
- Pension Card Number _____ Expiry __ / _____
- Workers' Compensation Insurance Company _____ Claim Number _____

How did you hear about us? GP ☐ Friend ☐ Website ☐ Optometrist ☐ Other _____

Medications _____

Allergies _____

Prior Eye History _____

Declaration

I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioners, Optometrist and insurance company where appropriate.

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian _____ Date _____

Name (Please print) _____