Patient Registration Form

Gladesville Eye Specialists

Title		Full Name			
Address					
Home Phone			Mobile		
Occupation			DOB		
Email Address					

Emergency Contact Details / Next of Kin

Name		Phone	
Relationship			

Medical Correspondence

GP Name **REQUIRED**		Suburb	
Optometrist Name		Suburb	
Are there any other medical practitioners you would like copied on your correspondence apart from the above?			
Name		Address	
Name		Address	

Privacy Statement

Our practice will need to collect your personal information to provide health services to you. Our main purpose for collecting, using, holding and sharing your personal information is to manage your health. Consistent with our approach to best practice and quality patient care, this practice has developed a policy to protect patient privacy in compliance with the *Privacy Act 1988 (Cth)*. We may use the information you provide for the following purposes:-

- to help us manage our accounts and administrative services, including billing, arrangements with health funds, pursuing unpaid accounts and management of our IT systems
- for consultations with other doctors and allied health professionals involved in your healthcare
- to obtain, analyse and discuss test results from diagnostic and pathology laboratories
- for identification and insurance claiming
- to liaise with your health fund, government and regulatory bodies such as Medicare and the Department of Veteran's Affairs.

I have read, or had read to me the above information and consent to the collection and use of my personal information for the reasons outlined above. I am aware that this practice has a privacy policy which is available upon request.

Patient Name _____

Signed _____ **Date** _____