To assist us in the book-keeping necessary for you to claim Medicare or other rebates, would you please fill in your details below. Please ask for us to assist you if necessary.
Your personal information is *confidential*

TITLE: Mr / Mrs / Miss / Ms / Dr

FIRST NAME: ______________________ SURNAME: ____________________

Date of Birth: ___________________

PHONE: Mob: _________________ Hm: ____________ Wk: ___________

TEXT MESSAGE REMINDER FOR FUTURE APPOINTMENTS: **YES / NO**

ADDRESS: ____

SUBURB: POSTCODE:

NEXT OF KIN:
Mr/Mrs/Miss __________________________ ____________________________
First Name Surname

RELATIONSHIP to you: *e.g. husband/wife etc* ________________________

NEXT of KIN CONTACT No:

MEDICARE CARD NO: __ __ __ __ / __ __ __ __ __ / __

REF NO: _____ *(number on left hand side of your name)*

EXP DATE: _________

GOLD CARD VETERANS AFFAIRS: _____________________

AGED PENSION NO: __ __ __ __ __ __ __ __ __ __ *(not health care card)*

PRIVATE HEALTH- HOSPITAL COVER ONLY
NAME OF FUND: MEMBER NO:

REFERRING DR/OPTICIAN: ____

YOUR LOCAL GP/CLINIC NAME: ____________________________________

YOUR GP ADDRESS: ____

I CONSENT TO ADELAIDE EYE AND RETINA CENTRE COLLECTING AND DISCLOSING MY INFORMATION IN ACCORDANCE WITH THEIR PRIVACY POLICY.

SIGNATURE ____________________________ DATE: _____________

I CONSENT TO ADELAIDE EYE AND RETINA CENTRE TO THE ANONYMOUS USE OF ANY PHOTOGRAPHS OR SCANS TAKEN OF THE BACK OF MY EYE IN PRESENTATIONS FOR TEACHING PURPOSES.

SIGNATURE ____________________________ DATE: _____________