# BALLARAT EYE CLINIC
# PATIENT REGISTRATION

**Personal details**

Title: Mr / Mrs / Ms / Miss / Mst / Dr   (please circle)

Surname: ______________________________________________

Given name/s: ______________________________________________

Date of birth: ______________________________________________

Residential address: ______________________________________________

______________________________________________

Postal address (if different from above): ______________________________

______________________________________________

Phone: ________________ Mobile: ________________ Business: ____________

**Referring Doctor/Optometrist:**

______________________________

**Name of you usual Doctor/GP:** ______________________________

**Emergency contact**

Name: ______________________________________________

Relationship to you: ____________________ Phone: ____________________

**Medicare number:** ______________________________ Expiry date:___/____

Reference number (this is the number in front of your name on the card: _____

**DVA Card number (if applicable):** ______________________________

Gold / White (please circle)

**Pension / Healthcare card number:** ______________________________

Expiry date: ________________

**Private health insurance:** Yes / No  Name of health fund: ________________

Member number: ______________________________

**Workcover / TAC number (if applicable):** ______________________________

Please bring all relevant paperwork

**- PLEASE TURN PAGE OVER -**