BALLARAT
EYECLINIC

If you have not already organised a **referral**, please do so **before your appointment**. If you do not have a referral at the time of your appointment you will not be able to claim any of your account back on Medicare.

Please arrive at your appointment time (no earlier) and allow 90 minutes for your appointment. We endeavour to see patients as close to their appointment time as possible but due to urgent or complicated cases, there may be some delay on occasions.

We ask that **only the patients** attend their appointment due to limited space in our clinic and your driver waits in the car or outside unless you medically require someone to be with you.

During your appointment it may be necessary to use drops to dilate your pupils for a comprehensive eye exam. These drops take 30 minutes to work and last 2-3hrs. Therefore, **it is advised that you do not drive to or from your appointment.**

Patient drop-off parking (5 mins) is available in the driveway of 8 Drummond St North. Metered parking is available on surrounding streets.

If you wear glasses , please bring them to your appointment.

Payment of fees is required in full on the day

This private practice does **NOT bulk bill**

DVA will be billed directly for Veterans

		Full Fee	Concession
Initial consultation	(104)	$189.50	$162.50
Follow up consultation	(105)	$108.00	$95.50
Children under 12yo	(109)	$251.00	$239.00

These are consultation fees only, additional eye testing will incur extra fees

8 Drummond Street North,
Ballarat, 3350
Victoria

All correspondence to:
PO Box 520W
Ballarat West Post Office 3350

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ballarateyeclinic.com.au

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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

BALLARAT EYE CLINIC
MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Patient Information

Full name: ______________________ DOB: ____________

Usual GP: ______________________________________

Past Medical History

Please complete the following to assist in obtaining a complete medical record.
Tick Yes or No & give details in the space provided.

	YES	NO	DETAILS e.g: year, diagnosis, etc
Major illness or disorder	▢	▢	____________
Major surgery	▢	▢	____________
Respiratory disease	▢	▢	____________
Stroke	▢	▢	____________
Heart attack	▢	▢	____________
High blood pressure	▢	▢	____________
Arthritis	▢	▢	____________
Kidney disease	▢	▢	____________
Diabetes	▢	▢	Type: _____ Year Diagnosed: _______ Control: insulin, tablets, diet (circle)

	YES	NO	DETAILS e.g: name of tablet
Do you take blood thinners	▢	▢	____________
Do you take Plaquenil	▢	▢	____________

Do you or have you ever taken **Duodart**, **Flomaxtra**, **Xatral, Hytrin** or **Carduran**? If yes, please circle which one.

What medications do you take? If yes, please list below. (If you have a medication list, please give it to the receptionist to scan into your file).

____

Do you have any allergies? Please circle: NIL KNOWN / YES
If yes, please list below.

____

Past Ocular History

	YES	NO	DETAILS e.g: name of drop
Glaucoma	▢	▢	____________
Lazy eye/eye turn	▢	▢	____________
Eye surgery	▢	▢	____________
Laser corrective surgery	▢	▢	____________
Family eye disease	▢	▢	____________
Do you wear contact lenses	▢	▢	____________
Do you use eye drops	▢	▢	____________

- PLEASE TURN PAGE OVER -

BALLARAT EYE CLINIC
MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Privacy & Financial Statement (all new patients to sign)

As part of The Ballarat Eye Clinic, a medical record containing your personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your consultation and if necessary for the continuity of your medical care. This information may be shared with other health practitioners involved in your care and treatment. In certain circumstances, there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available upon request.

I have been made aware that payment in full is required on the day of my appointment.

Print Name: ____

Signed: ______________________________ **Date:** ____________

Private Health Insurance

Many patients are unaware of exactly what their level of cover entitles them too. If you are privately insured, please check with your private health insurance company prior to your appointment if you think it is possible you may be booked for a procedure.

- Have you been a member of your health fund for less than one year? Yes / No (please circle)
- Are there any procedure exclusions (in particular eye procedures)? Yes / No
- Do you have an excess to pay on your health fund? Yes / No
- Are you covered for a private and/or public hospital? Yes / No

A written quote will be provided for all procedures booked