

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 require a medical carer.

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

		<b>Full Fee</b>	<b>Concession</b>
Initial consultation	(104)	\$200.00	\$172.00
Follow up consultation	(105)	\$114.00	\$101.00
Children under 9yo	(109)	\$264.50	\$252.00

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

8 Drummond Street North,  
Ballarat, 3350  
Victoria

All correspondence to:  
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Ballarat West Post Office 3350

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[ballarateyeclinic.com.au](http://ballarateyeclinic.com.au)

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Ophthalmologist  
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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: \_\_\_\_\_ Email: \_\_\_\_\_

**Referring Doctor/Optomtrist:** \_\_\_\_\_

**Name of your 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: \_\_\_\_\_ Next of Kin: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Are you Aboriginal or Torres Strait Islander YES  NO

### 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Year Diagnosed: _____ Control: insulin, tablets, diet (circle)

	YES	NO	DETAILS e.g: name of tablet
Do you take blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take Plaquenil	<input type="checkbox"/>	<input type="checkbox"/>	_____

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).

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

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### Past Ocular History

	YES	NO	DETAILS e.g: name of drop
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye/eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laser corrective surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family eye disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

# BALLARAT EYE CLINIC

## MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Do you wear contact lenses   \_\_\_\_\_  
Do you use eye drops   \_\_\_\_\_

### 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

**Follow Up/Post-Op Consultation Fee:**

**Non Concession Card Holders:**

\$114.00 (Medicare Rebate/Refund = \$38.60)

**Concession Card Holders:**

\$101.00 (Medicare Rebate/Refund = \$38.60)

If you have any questions regarding fees or requiring more information regarding our out of town surgery clinics please phone our rooms directly.

Thank you

The Ballarat Eye Clinic

5333 1095