Dr Charles Su - Oculoplastic Surgeon

Patient Registration form

Please fill out this form and return it as soon as possible.

If you have a valid referral to cover your appointment, you will be able to claim a Medicare rebate after payment (or a rebate from your overseas health cover if this is relevant to you). Please also be aware that clinic appointments are **not** covered by health insurance. Hospital health insurance cover only applies to admission to hospitals or day surgery if your policy covers the relevant procedure.

Section A: **Personal details**

Title	**First Name** (as displayed on Medicare card)	**Surname**

Date of Birth	**Preferred Name**

Home Street Address	**Suburb**	**State**	**Postcode**

Postal Address (if different from above)

Primary Contact Number	**Home Phone**	**Alternative Contact**

Email

Medicare Number	**Your Reference Number**	**Expiry Date**

Pension Card Number(Blue and purple card)	**Expiry Date**

Veteran's Affairs Number	**Card Type**	**If White card, condition (s) covered**

Is your problem related to a TAC or Workcover claim? ☐ **Yes** ☐ **No**

TAC/Workcover Claim number (Please supply a copy of the TAC/Workcover claim paperwork)

Do you have Hospital cover for Private Health Insurance? (+ 1 year) ☐ **Yes** ☐ **No**

Health Insurance Fund Name	**Membership Number**	**Health Insurance Level of Hospital Cover** (Not extras)

Section B: **Next of Kin** (If your next of kin is your medical Power of Attorney, please supply a copy of the Power of Attorney document)

Name	**Relationship**	**Contact Number**

Email

Address (eg. Apt 1, 23 Smith Street, Melbourne VIC 3000)

Do you give permission for the clinic to contact your N.O.K if we are unable to contact you? ☐ **Yes** ☐ **No**

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Section B: **Medical History** (Please provide a GP health summary if you have complicated health history)

Name of your Local Doctor	Clinic Name	Clinic Phone Number

Clinic Address (eg. Apt 1, 23 Smith Street, Melbourne VIC 3000)

Name of your Optometrist	Clinic Name	Clinic Phone Number

Clinic Address (eg. Apt 1, 23 Smith Street, Melbourne VIC 3000)

List of Health Issues

List of Current Medications

List of Known Allergies

List of Past Operations

Section C: **Consent**

We aim to protect the privacy and secure storage of your health information.
We require your consent to collect personal information about you and to use the information you provide in the following ways.

- Billing purposes and Administrative purposes in running our medical practice.
- Disclosure to others involved in your healthcare
- For research and quality assurance activities (De-identified) you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

I give consent for my personal information being using in the ways listed above

Signature of Patient or Guardian	Date

Please notify us promptly of any changes in your contact details.