noosa
ophthalmology
EYE SPECIALISTS

NEW PATIENT REGISTRATION
& RELEASE OF INFORMATION AUTHORITY

Patient Details

Name: ..... Date of Birth: .....

Address: .....

Phone Nos: Home: ..... Mobile: .....

Would you like to receive a reminder via text message for future appointments?

(Please tick ☐): * Yes *No

Emergency Contact: ..... Emergency Contact Ph No: .....

Practitioners Details

Referring Practitioner: .....

Your G.P.: Dr.....at.....Surgery Address

Your Optometrist (if applicable) .....at..... Address

Medical History

Allergies: .....

Past/Present Medical Problems (Please tick ☐):

* Diabetes
* Hypertension
* Hepatitis
* Heart Disease
* Asthma
* Other (Please specify): .....

Past/Present Eye Problems (Please tick ☐):

* Glaucoma
* Eye Injury
* Cataract
* Squint Surgery
* Other Eye Surgery (Please specify): .....

Current Medications: .....

.....

Current Eye Drops: .....

I consent to the use of my personal health information by Noosa Ophthalmology and the disclosure of my personal health information to other health professionals to assist with my continuing care.

Signature .... **Date** .....