EyeQ Optometrists work hard to deliver the highest standards of eyecare, and that includes having a thorough understanding of your medical history. If this is your first visit with us please take a minute to fill out this form and bring it along to your appointment.

EyeQ OPTOMETRISTS
Experts in Eyecare

Personal Details

Date _____

Name ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss _____ (First Name) _____ (Surname) Date Of Birth_____ (dd/mm/yyyy)

Address _____

_____ Postcode_____

Contact Details
Home: _____ Email Address: _____
Work: _____ Preferred Contact Method:
Mobile: _____ SMS ☐ Home ☐ Email ☐ Office ☐ Post ☐ Mobile ☐

What is your Occupation?_____

Entitlements

We only charge the Scheduled and Recommended Fees, with most consultations directly billed to Medicare

Do you have any other entitlements that may cover some of our services?

Please tick the entitlements that apply to you:

Veteran's Affairs ☐ Pensioner ☐ Health Care Card ☐ Seniors Card ☐

Government Concession ☐ Issue Date ____/____ Expiry Date ___/____

Health Fund
Health Fund Name: _____
Member Number: _____ Reference Number: _____

Medicare Number: _____ Reference No: _____ Expiry ____/____

Department of Veteran's Affairs / Pension Number: _____ Expiry ____/____

Referrers

Who can we thank for referring you to our practice?

Name: _____ Address:_____

Doctor's name: _____ If needed, may we contact to provide a report? Yes ☐ No ☐

Medical History

This information helps us complete a visual record. Please tick the correct response.

Are you currently under a doctor's care? Yes ☐ No ☐

Do you have any allergies or hay fever? Yes ☐ No ☐

Is there any blindness in your family? Yes ☐ No ☐

Have you ever had:

Anaemia Yes ☐ No ☐

Stroke Yes ☐ No ☐

Arthritis Yes ☐ No ☐

Double vision Yes ☐ No ☐

Eye surgery Yes ☐ No ☐

Eye injury Yes ☐ No ☐

Abnormal blood pressure Yes ☐ No ☐

Serious head injury Yes ☐ No ☐

Frequent headaches Yes ☐ No ☐

Abnormal thyroid Yes ☐ No ☐

Blurry distance vision Yes ☐ No ☐

Are you pregnant Yes ☐ No ☐

Are you or anyone in your family diabetic? Yes ☐ No ☐

Have you had a recent illness? Yes ☐ No ☐

Have you or any family had glaucoma? Yes ☐ No ☐

Have any family had macular degeneration? Yes ☐ No ☐

Are you taking medication for:

Diabetes Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

Thyroid Yes ☐ No ☐

Birth control Yes ☐ No ☐

Other medication:_____

_____

_____

_____

Date of your last eye exam _____

By whom _____

Are you interested in trying contact lenses? Yes ☐ No ☐

Privacy Statement

This practice operates in accordance with the National Privacy Principles and all patient related information is held in strict confidence and will not be shared with any other person not related to your eye health. We may at times need to share your information with Medicare, your GP or your nominated health fund. Our complete Privacy Policy can be found online at www.eyeq.com.au.

☐ At times we like to update our patients on the latest practice news, eyewear offers and competitions. If you do not wish to receive this information by mail or email please tick this box.

Signature _____ Date _____

Thanks for taking the time to complete your details. Feel free to let us know if you have any questions on any of the information we've requested.