

# Patient Information

Wheatbelt Eye Clinic



Mr Mrs Ms Miss Master Other \_\_\_\_\_ (please circle)

First Name \_\_\_\_\_ Surname \_\_\_\_\_

Email \_\_\_\_\_ Home Ph \_\_\_\_\_

DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Mobile Ph \_\_\_\_\_

Address \_\_\_\_\_ Next of Kin \_\_\_\_\_

Suburb \_\_\_\_\_ Relationship \_\_\_\_\_

State \_\_\_\_\_ Postcode \_\_\_\_\_ Ph \_\_\_\_\_

Medicare            Ref # (before your name)

Health Insurer \_\_\_\_\_ Membership No. \_\_\_\_\_

Concession No. \_\_\_\_\_ (please circle) Age HCC Carer DSP JS

Dept Veteran Affairs Card Number \_\_\_\_\_ Colour \_\_\_\_\_

Referrer \_\_\_\_\_ Ph \_\_\_\_\_

Usual GP Name (if different from referrer) \_\_\_\_\_

Practice Name and Address \_\_\_\_\_

\_\_\_\_\_ GP Ph # \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PLEASE COMPLETE THIS FORM AND BRING WITH YOU**  
**OR FORWARD TO US BY EMAIL BEFORE YOUR APPOINTMENT**