HUNTER CATARACT & EYE CENTRE

Sky Central East

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**PATIENT INFORMATION SHEET**

Title: .................... First Name: ................................................ Surname: ..............................................................

Date of Birth: ................................................................ Occupation/Hobby: ………………………………………………………….

Address: ......................................................................................................................................................................

Suburb: .................................................................................... Post Code: ................................

Home Phone No: ............................... Work Phone No: ............................ Mobile No: ...................................

Medicare Number: .............................................. Ref No: (number next to name)..............Expiry Date: .................

Private Health Fund: ..................................................Membership No: ..................................................................

Pension Card / Health Care Card: ........................................................................Expiry Date: .............................

DVA Gold Card No: ..............................................................

Work Cover Details: .................................................................... Claim Number: ..................................................

**REFERRAL DETAILS**

Name of Referring GP/Specialist/Optometrist: .........................................................................................................

Address: ......................................................................................................................................................................

**If your current GP is not referring you to this clinic, please include the name and address, so a copy of your report can be mailed directly to their practice:**

Name: ...........................................................................................................................................................................

Address: ........................................................................................................................................................................

**NEXT OF KIN**

Title: .................... First Name: ................................................. Surname: ................................................................

Address: ........................................................................................................................................................................

Suburb: ........................................................ Post Code: .................... Contact No: ....................................................

**MEDICAL HISTORY:**

Please list all your current medications: .....................................................................................................................................................................................

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………………………………………………………………………………………………………………………………………………………………………………

Do you have a family history of Eye Disease? Y / N

If yes please list: ..........................................................................................................................................................

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Please list previous procedures/operations you have had (within the last five years): ............................................

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Are you diabetic: ....................

Do you have a current glasses prescription: Yes ............................... No.........................

**GENERAL INFORMATION:**

**Please bear in mind that Dr Manning may require further tests during your consultation - the prices are included on the following page:**

**We ask for full payment of your consultation on the day, these can be claimed back from Medicare.**