New Patient Form

InFOCUS EYECARE

Personal Details

First Name: _____ **Home Phone:** _____

Surname: _____ **Mobile Phone:** _____

Title: Mr / Mrs / Ms / Miss / ___ **D.O.B:** _ _ / _ _ / _ _ _ _ **Gender:** Male / Female

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Occupation: _____

How many hours spent per day on: Computer __ Laptop __ Tablet __ Mobile __

Preferred Contact Method/s (tick all that apply)**:** ☐ Post ☐ Home Phone ☐ Mobile Phone ☐ SMS ☐ Email

☐ Tick if you agree to receive appointment reminders, our monthly newsletter and other correspondence from In Focus Eyecare

Health Care Details

Medicare Number: _____ Ref #: ____ Expiry:_____/ _____

Private Health Fund: ☐ No ☐ Yes (Name) _____

GP's Name:_____ **Phone Number**: _____

☐ Tick if you agree to In Focus Eyecare routinely updating your doctor with your eye tests results.

General Health Details

Tick all that apply	**Your History**	**Family History**	**Relation to you**
Diabetes	☐	☐ Type 1 ☐ Type 2	
Macular Degeneration	☐	☐	
Glaucoma	☐	☐	
Cataracts	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	

Are you a smoker: ☐ No ☐ Yes (How Many Years) __ (Quit Date) _____/_____

Are you currently taking any medications: ☐ No ☐ Yes (details) _____

_____

General Health Notes _____

_____ **Continue Over....**

Privacy Statement. The above details have been collected with your authority and will form part of your confidential file. This information will be stored securely at In Focus Eyecare and not shared or sold to any third party. You can request a copy of your details on file at any time.

Eye Health Details

When was your last eye test? _____ **Where**? _____

Are there any specific eye concerns you would like to discuss today?

□ Distance vision blurry □ Close vision blurry □ Red / sore / itchy / watery / dry eyes □ Double Vision

□ Headache □ Eye strain □ Eye ache □ Flashes □ Floaters □ Glare problems – Day / Night □ Other

If yes to any of the above, please provide details including the severity and frequency of the issue

_____

_____

Have you had any eye: □ Surgery □ Injury □ Disease?

If yes to any of the above, please provide details when, what and any permanent damage _____

_____

Do you wear spectacles: □ No □ Previously but not now □ Yes (provide details including how long you have worn them for, what type and are you happy with them?) _____

_____

Do you wear contact lenses: □ No □ Previously but not now □ Yes (provide details including how long you have worn them for, what type and are you happy with them?) _____

_____

Would you like to try contact lenses: □ No □ Yes

Do you have prescription sunglasses: □ No □ Yes (polarised / transition/ tint only)

If recommended by your optometrist, do you agree to have the following procedures today?

	Yes	**No**
Eye Pressure test (for glaucoma) (with eye drops if required)	□ Medicare Bulk Billed	□
Visual Field Testing	□ Medicare Bulk Billed	□
Retinal Photography	□ $39 Charge with file sent to your email on request	□
Advanced Glaucoma and Macular Degeneration Screening (OCT scan)	□ $70 Charge with file sent to your email on request	□
Orthokeratology	□ $1,650 with 1 pair of lenses and unlimited consults	□

How Did You Hear About Us

□ Referral (who) _____ □ Website □ Facebook □ Google / Search

□ White / Yellow Pages □ Walking Past □Flyer □Other_____

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