WELCOME TO OPTIONS EYECARE

TITLE:..... FIRST NAME:..... SURNAME:.....

KNOWN AS:.....DOB:..... / ..... / .....

NAME OF PARENT/GUARDIAN (IF UNDER 18YRS):.....

ADDRESS:.....

SUBURB.....P/CODE:..... HOME PHONE:.....

WORKPHONE:.....MOBILE.....EMAIL.....

OCCUPATION:.....NAME OF GP.....

DO YOU HAVE PRIVATE HEALTH FUND WITH EXTRAS? ☐ No ☐ Yes (name of fund): .....

DO YOU HAVE *(Please Tick)*: ☐ **VETERAN AFFAIRS CARD** ☐ **HEALTH CARE CARD** ☐ **PENSION CARD**

WHICH IS THE BEST WAY TO CONTACT YOU, AND TO CONFIRM APPOINTMENTS? *(Please tick your first preference below)*

☐ SMS ☐ Email ☐ Mail ☐ Home Phone ☐ Work Phone ☐ Mobile Phone

Do you consent to receiving occasional email communications to the above email address, regarding eye health information and relevant promotions? (Please be assured you can unsubscribe at any time via the link provided in each email) ☐ *Yes, please include me.*

HOW DID YOU HEAR ABOUT OPTIONS EYECARE?

☐ Yellow Pages/YP Online ☐ Social Media
☐ Location/Convenience ☐ Doctor's Referral
☐ Options Website ☐ Family / Friend →

*Options have a referral program that rewards those who show confidence in our organisation and refer friends and family. *If you were referred to our practice, who may we thank?*.....

When was your last eye examination.....Is there a reason for your visit today? .....

Do you currently wear glasses? ☐ Yes ☐ No If yes, approximately how old are they?.....

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what brand are they?.....

If no, would you like more information about contact lenses? ☐ Yes ☐ No

Do you spend significant time on a computer? ☐ Yes ☐ No

Do you have a dedicated pair of computer spectacles? ☐ Yes ☐ No

Please list any sports, hobbies or special interests you have below:

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Do you spend a lot of time outdoors? ☐ Yes ☐ No

Do you wear prescription sunglasses? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No

MEDICAL HISTORY - Do you or a close blood family member suffer from any of the below conditions: *(Please circle)*

	YOURSELF	BLOOD FAMILY MEMBER	
Glaucoma	Yes / No	Yes / No	Who?.....
Cataracts	Yes / No	Yes / No	Who? .....
Macular Degeneration	Yes / No	Yes / No	Who? .....
Allergies	Yes / No	Yes / No	Who? .....
Eye Injury	Yes / No	Yes / No	Who? .....
Other eye conditions (Inc Infections)	Yes / No	Yes / No	Who/What? .....

Do you have any other health issues? Yes / No If yes, please specify.....

Are you currently on any medication/s? (Some medications may affect your vision) Yes / No If yes, please specify below.

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*While nearly all of our services are covered by Medicare they are no longer Bulk-Billed. As a result, for a comprehensive consultation up to 30 minutes your minimum out of pocket cost will be $20 ($10 for Concession and school-aged children). Once you've made payment in full on the day we can process your Medicare rebate immediately through Medicare Online and it will deposited to your nominated bank account usually within ½ an hour leaving you with that $20 ($10 for Concession and school-aged children) out of pocket cost"

YOUR PRIVACY *-Thank you for choosing Options Eyecare to care for your vision needs. In order to provide the best service and to maintain the accuracy of our records, we thank you for providing the above details. Please be assured that the information we collect and hold is handled with the utmost confidentiality and security measures in accordance with the Privacy Act.*

I confirm that all the information I have provided you is correct. Signature..... ***Date***.....

Did you know we are on Facebook? Like us at ***www.facebook.com/OptionsEyecare*** *for optical news and special offers!*