cura
ophthalmology specialists

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Patient Registration Form - Adult

Patient Details

Title _____ Given Names _____ Surname _____

Date of Birth _____ Gender _____ Email _____

Home _____ Mobile _____ Language Spoken at Home _____

Address _____

Suburb _____ State _____ Postcode _____

Medicare/ Private Health Details

Medicare Number |__|__|__|__| |__|__|__|__|__| |__| Number preceding your name |__| Expiry |__||__| / |__|__|

Health Insurance Fund _____ Member No. _____

Type of Cover _____ Excess Amount _____

Vet. Affairs Number: _____ ☐ White Card ☐ Gold Card

Workers' Compensation Claim Number _____

Current GP

Name _____

Date of Referral _____ Phone Number _____

Address _____

Suburb _____ State _____ Postcode _____

Current Optometrist

Name _____

Date of Referral _____ Phone Number _____

Address _____

Suburb _____ State _____ Postcode _____

I certify that the information given above is correct to the best of my knowledge. I understand that I am liable for all charges associated with the consultation and that a cancellation fee of $80 will be charged if I cancel my appointment with less than 24 hours notice.

Signature of patient _____ Date _____

Please print name: _____