

**Queensland Eye Hospital**

Leichhardt Court
55 Little Edward Street
Spring Hill, QLD 4000

www.qldeye.com

Telephone: (07) 3236 9844
Facsimile: (07) 3236 9855

IMPORTANT:

Please **COMPLETE & RETURN** to:
P.O. Box 293, Spring Hill, QLD, 4004
FAX: (07) 3236 9855

Please return at least 1 week prior to the procedure

OFFICE USE ONLY

UR No:

Initials:

Date:

PATIENT'S DETAILS FORM

Proposed Admission Date:

Surgeon's Name:

Procedure:

Have you been a patient of Queensland Eye Hospital? ☐ Yes ☐ No If yes, when:**Patient Details***PATIENT TO COMPLETE*

(Dr/ Mr / Mrs / Ms / Miss / Child)

Surname:

Given Names:

Preferred Name:

Date of Birth:

☐ Female ☐ Male

Marital Status:

Address:

Post Code:

PO Box (if applicable):

Phone Home:

Mobile:

Work:

Country of Birth:

Contact NAME and NUMBER if in
Brisbane **PRIOR** to procedure :Do you have an email address where we can send a message if we are unable to contact you by
phone prior to your admission? if Yes details _____**Emergency Contact (e.g. Next of Kin)***PATIENT TO COMPLETE*

Name:

Relationship:

Address:

Post Code:

Phone Home:

Mobile:

Work:

Billing / Health Insurance Details*PATIENT TO COMPLETE*

Medicare No: _____

Ref. No.: _____
(next to name)

Expiry Date: ____ / ____ / ____

Pension: ☐ Yes ☐ No

No.: _____

Dept. Veterans' Affairs

(No.): _____

Health Fund Name:

Membership No.:

Workers Compensation (Claim No.):

Person Responsible for Account*PATIENT TO COMPLETE*

Name:

Relationship:

Address:

Post Code:

Phone Home:

Mobile:

Work:

Power of Attorney*PATIENT TO COMPLETE*Does someone hold a medical/enduring Power Of Attorney over you: ☐ Yes ☐ No

* F E D E T 1 *