Queensland Eye Hospital
Ground Floor, Leichhardt Court
55 Little Edward Street
Spring Hill QLD 4000
Ph: (07) 3236 9844

IMPORTANT:
Please COMPLETE & RETURN at least 1 week prior to:
Queensland Eye Hospital
P.O. Box 293, Spring Hill, QLD, 4004
Ph: (07) 3236 9844 Fax: (07) 3236 9855
Email: info@qldeye.com

OFFICE USE ONLY
UR No:
Initials:
Date:

PATIENT DETAILS FORM

Proposed Admission Date:	**Surgeon's Name:**
Procedure:	
Have you been a patient of Queensland Eye Hospital? ☐ Yes ☐ No	**If yes, when:**

Patient Detail *PATIENT TO COMPLETE*

(Dr / Mr / Mrs / Ms / Miss / Child)	**Surname:**	
Given Names:		**Preferred Name:**
Address:		**Post Code:**
Date of Birth:	**☐ Female ☐ Male**	
Home Phone:	**Work:**	**Mobile:**
Email Address:		
PO Box (if applicable):		
Do you have an Aged Pension card? ☐ Yes ☐ No	**If yes, Card Number: _ _ _ _ _ _ _ _ _ _**	
Marital Status:	**Country of Birth:**	
Do you Identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No _____		
Do you have a My Health Record? ☐ Yes ☐ No		
Contact NAME and NUMBER if in Brisbane PRIOR to procedure:		

Billing / Health Insurance Details *PATIENT TO COMPLETE*

Medicare Card No.: _ _ _ _ _ _ _ _ _ _	**Ref. No.: _____**	**Expiry Date: _ _ / _ _ _ _**
Dept. Veterans' Affair: _ _ _ _ _ _ _ _ _ _	**Workers Compensation (Claim No.):**	
Health Fund Name:	**Membership No.:**	

Emergency Contact (e.g. Next of Kin) *PATIENT TO COMPLETE*

Relationship:	**(Dr / Mr / Mrs / Ms / Miss)**	**Name:**
Address:		**Post Code:**
Home Phone:	**Work:**	**Mobile:**

Person Responsible for Account *PATIENT TO COMPLETE*

Relationship:	**(Dr / Mr / Mrs / Ms / Miss)**	**Name:**
Address:		**Post Code:**
Home Phone:	**Work:**	**Mobile:**

Power of Attorney *PATIENT TO COMPLETE*

Does someone hold a medical/enduring Power Of Attorney over you: ☐ Yes ☐ No
If yes, please provide copy to staff at admission.

BARCODE 1