DR DANIELLE (DAINI) ONG
DR WENG NG
DR RAHGU KINI
DR MICHAEL CHEN

VALLEYCARE EYE DOCTORS

PATIENT DETAILS

1. Contact Details:

Title: _____ First Name: _____ Family Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

Telephone: Home _____ Work _____ Mobile _____

Email: _____

2. Medicare/Concession:

Medicare Card No: _____ Ref No: _____ Expiry: _____

Pension/Healthcare Card No: _____ Expiry: _____

Veterans' Affairs Gold Card VX No: _____ Expiry: _____

Private Health Hospital Insurance: _____ Member No: _____

3. Emergency Contact:

Next of Kin: _____ Relationship: _____

Telephone: Home _____ Mobile _____

4. Health Care Practitioners:

Usual Optometrist Name: _____

Optometrist Clinic: _____

Usual General Practitioner Name: _____

General Practitioner Clinic: _____

5. Health Summary:

Diabetes (please tick): Non-Insulin Dependent ☐ Insulin Dependent ☐ No ☐

Allergies: _____

List of Medications (including eye drops/ointments): _____

_____

_____

DR DANIELLE (DAINI) ONG
DR WENG NG
DR RAHGU KINI
DR MICHAEL CHEN

VALLEYCARE EYE DOCTORS

IMPORTANT: For an initial eye examination it is usually necessary to dilate the pupils. This means that your vision will normally be too blurred for safe driving for about two (2) hours. If this is a problem, please let us know to enable rescheduling of this part of the examination.

Please bring all of your current spectacles with you to the appointment.

We suggest that you allow **TWO HOURS** for your visit.

Privacy Policy: When you become a patient of ValleyCare Eye Doctors, we require you to provide us with your personal information and your medical history. The information is collected for billing and receipting purposes and to assist in providing assessment, diagnosis and treatment of your ophthalmological needs.

As part of our privacy policy we ensure your personal details and health information are private and confidential and will be stored and treated as such and can only be accessed by authorised staff. However, in some cases your information may need to be disclosed to third parties, such as other health professionals, to determine, with your consent, the best possible outcome and treatment that is right for you. If there are any changes to your information, please advise us so that we are able to accurately maintain your record.

Disclosure: We will never disclose your personal information without your consent, with the exception of police request or subpoena by a court of law.

Disposal: Medical records are required to be kept for a period of time and when no longer required all confidential documentation is destroyed in a secure manner.

Access: Upon request you are able to access your medical record if there is sufficient reason to do so.

Agreement and Consent: By signing this document you understand our practice policy information that is outlined above and consent to disclosure of your information to a third party (eg. other health professional) only when considered beneficial to your medical treatment.

SIGNATURE: _____ Date: _____

Print Form