

Coastwide Eye

Patient Registration

Erina
Suite 1:07 Platinum Building
4 Ilya Avenue
ERINA 2250
(02) 4365-9444

Tuggerah
Suite 1/23-25
Anzac Road
TUGGERAH 2259
(02) 4355-5600

Welcome to our Practice.

Please fill in the following details and bring this form with you to your appointment.

Personal Details

Family Name: _____ Mr/Mrs/Ms/Miss/Master/Dr/Other _____

Given Names: _____ Date of birth: _____

Address: _____

_____ Postcode

Telephone No: (Home) _____ (Work) _____ (Mobile) _____

Medicare No: _____ Card No: _____ Expiry date: _____

Pension No/ Health Care Card No: _____ Expiry date: _____

Department of Veteran Affairs No: _____

Are you privately insured Yes / No (Please circle)

Private Health fund: (Name) _____ Membership No: _____

Interested parties

Please list the details of any interested party whom you would like to receive a letter following today's consultation

Referred by: (Name) _____ (Phone No) _____

(Address) _____

Local GP: (Name) _____ (Phone No) _____

(Address) _____

Optometrist: (Name) _____ (Phone No) _____

(Address) _____

Specialist: (Name) _____ (Phone No) _____

(Address) _____

List of your current medications

