TOOWOOMBA OPHTHALMIC CONSULTANTS

Dr David Holcombe
FRANZCO MBBS PhD BSc Senior lecturer UQ
Advanced Cataract Surgery | Macula & Medical Retina
p: (07) 4670 9666 f: (07) 4670 9677
www.toowoombaOC.com.au
20 Goggs Street, Toowoomba 4350
reception@toowoombaOC.com.au

Personal Information

Title:	First names:	Preferred name:	Surname:	DOB:

Residential address:	Suburb:	City/Town:	Postcode:

Home phone: ( )	Mobile phone:	Work phone: ( )

Email: **Occupation:**

Medicare number:

_ _ _ _ _ _ _ _ _ _ **Expiry:** _ _ / _ _ _ _

Ref number (next to name): _

Department of Veterans Affairs: YES NO

Please circle: Gold card White Card

DVA Number:

Private Health Fund: YES NO

Fund name:

Member number:

Age pension: YES NO

Pension number: **Expiry:**

Next of kin / emergency contact

Name:	Relationship:	Contact number: ( )

Regular Health Practitioner Details:

General Practitioner:

Clinic:

Address:

Optometrist:

Clinic:

Address:

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Your Information and Privacy Disclosure:

This practice, by necessity, collects personal details about its patients. We regard your information as confidential. This information is used for patient care at our practice and in communication with external health professionals involved in the patient's care. By filling out our forms containing your information you are giving your consent for this practice to collect and store information about you, and to use it in communication within the practice and with external health professionals in relation to your ongoing care. Our privacy policy is available through our website: toowooombaOC.com.au

Often the patient's relatives and friends call to enquire about their wellbeing or to offer assistance in the patient's care. Please indicate by circling the appropriate option with whom you give us permission to discuss your medical condition.

☐ **Nobody-** I want to be the only person who communicates with this practice about my medical condition.

☐ **Family members-** I freely give my consent for this practice to communicate, as required, with family members about my medical condition.

☐ **Friends-** I freely give my consent for this practice to communicate, as required, with friends about my medical condition.

Please note this is a private billing clinic. Payment on the day of consultation is required. Services are provided by Dr David Holcombe (ABN 63 441 663 813). For more information on our fees, please ask one of our friendly reception staff.

I_____ consent to the use and disclosure of my personal information as outlined above.

Signed:_____ Date:_____
Parent/Guardian to sign if patient is under 18 years.