Welcome to Total Optical

Thank you for choosing our practice. Please provide the following information:

PATIENT DETAILS

Title: Surname: Given Names:

Date of birth: / / Occupation: Gender: ☐ Male ☐ Female

Address: Postcode:

Home phone: Work phone: Mobile:

Email: What is your preferred method of contact? Phone Home / Work / Mobile / Email

GP's Name: GP's Address:

Are you covered by a private Health Fund? ☐ Yes ☐ No Health Fund Name:

When was your last eye examination?

LIFESTYLE CONSIDERATIONS

Do you have any hobbies, sports or special interests? ☐Yes ☐No
If yes, please specify:

Do you require safety glasses for occupational or sporting activities? ☐Yes ☐No
If yes, please specify:

Do you work on a computer for extended periods? ☐ Yes ☐ No

Do you spend a lot of time outdoors? ☐Yes ☐ No

Do you wear prescription sunglasses? ☐ Yes ☐ No

Are you currently wearing spectacles? ☐ Yes ☐ No If yes, approximately how old are they?

Are you currently wearing contact lenses? ☐Yes ☐ No If no, would you like to know more about them? ☐ Yes ☐ No

MEDICAL HISTORY

Please indicate if you or a member of your family have ever experienced any of the following:

☐ Eye Injury ☐ Lazy Eye ☐ Glaucoma ☐ Cataracts
☐ Eye Surgery ☐ Heart Disease ☐ Allergies ☐ Diabetes
☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke ☐ Macular Degeneration
☐ Other, please specify:

Are there any particular concerns or questions you have about your vision or eye health? ☐ Yes ☐ No Please specify:

HOW DID YOU FIRST HEAR ABOUT OUR PRACTICE?

☐ Friend or relative. Name: ☐ Yellow Pages ☐ Other, please specify:

☐ Previous patient. Name: ☐ Yellow Pages Online

☐ Health Care Practitioner. Name: ☐ Location

PRIVACY STATEMENT

Our practice respects your privacy and will comply with the Privacy Act and the National Privacy Principles when handling your personal information. We use your personal information to help us provide services to you and with your permission, to send you information regarding eye health, eye care and eyewear. If you do not provide information requested in this form we may be unable to provide services to you, or our ability to do so may be impaired. You can access most personal information that we hold about you. Please contact us if you would like to know more about how we handle your personal information.

Are you happy for us to send you eye health, eye care and eyewear information from time to time? ☐ Yes ☐ No
Are you happy for us to send you eye health, eye care and eyewear information electronically (for example by SMS or email)? ☐ Yes ☐ No

Are you happy for us to provide your personal contact information to our product suppliers, partners and service providers to assist us in sending you this information (and for no other purpose)? ☐ Yes ☐ No

Signature: Date: / /