Welcome to Light Optometry & Vision Therapy
We would like to learn more about you

Title (please tick) Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Mstr ◯ Dr ◯ Other (specify)	Given names	Surname
Preferred name (if different from above)	Date of Birth	

Contact details

Residential address
Postal address (if different from above)

Phone numbers – please circle or tick preferred contact number

Home	Mobile	Work
Email		

Health Fund	Member number	Reference number
Medicare number	Reference number	Expiry

Information and Marketing

Very occasionally we may send out information on education relating to eye care and disease, promotional offers, invitations to events and our practice newsletter. Do we have your permission to send this material to you?

◯ Yes ◯ No If yes, how would you prefer this sent: ☐ SMS ☐ email ☐ mail

Referred by	Or How did you hear about us?

General Practitioner

Name	Address	Contact number

Medical & Family History

Please advise us if any of the following apply to you:

Eye injury ☐	Eye surgery ☐	Glaucoma ☐	Diabetes ☐	Cataracts ☐
High blood pressure ☐	High cholesterol ☐	Heart disease ☐	Allergies ☐	Lazy eye ☐

Other

Please advise us if anyone in your family has had:

Lazy eye ☐	Glaucoma ☐	Heart disease ☐	Diabetes ☐	Macula Degeneration ☐

Other, please specify

Please list any medications that you currently take:

Vision

Do you wear glasses? ◯ Yes ◯ No	Do you wear contact lenses? ◯ Yes ◯ No

Do you have any special interests, hobbies, sport or other activities that require good or specialised vision? (please specify)

Do you have any other visual needs or concerns that you would like to discuss today?
As part of a comprehensive eye examination we may need to dilate your pupils to thoroughly examine your eyes. This can cause minor blurred vision and glare sensitivity for about 4 hours. Some people prefer not to drive following dilation. If this is necessary, are you able to have your pupils dilated today or would you prefer to reschedule dilation for a more convenient time?

☐ Dilate my pupils today	☐ I understand that a dilated exam is important to allow a thorough eye exam, but I decline to have this procedure done
☐ Reschedule for dilation	

Privacy Statement
At Light Optometry and Vision Therapy your privacy is important to us. Your personal information that we collect and hold about you is handled with confidentiality and security and in accordance with the Privacy Act.
I authorise that all the information that I have provided is correct Signature: Date:

Submit