Eastern Haematology Oncology Group

NEW PATIENT REGISTRATION FORM

Title (circle) Mr Mrs Ms Dr	Other
First name	
Surname	
Middle name(s)	

Address	
Suburb	
State	Postcode
Aboriginal? YES / NO Torres Strait Islander? YES / NO	

Date of birth (DD/MM/YYYY) / /
Gender (circle) Male Female
Home phone
Mobile phone
Email

Account type
Private DVA WorkCover AC Other:

Account holder details (if different to above)	
Name	
Address	
Suburb	Postcode
Phone	

Referring doctor	
Name	
Address	
Suburb	Postcode
Phone	

General practitioner details (if different to above)	
Name	
Address	
Suburb	Postcode
Phone	

Medicare number	Ref no.
Medicare expiry /	
Health fund	
Health fund membership number	
DVA number (if applicable)	

Marital status
Next of kin details
Name
Address
Suburb / Postcode
Phone
Relationship to patient

Eastern Haematology Oncology Group

Personal & Health Information Consent

We respect your rights to privacy and takes our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- www.ehog.com.au
- Our reception
- By calling 03 9459 5333

We require your consent to collect personal information and health information about you. Please read this information carefully, and sign where indicated below.

Eastern Haematology Oncology Group collects information from you for the primary purpose of providing you with healthcare services. We require you to provide us with your personal and health information including your full medical history so that we may provide our services to you. We will also use the information you provide in the following ways:

- appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff;
- effectively communicate with third parties, including the Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me.

Patient name	
Date (DD/MM/YYYY)	
Patient signature	
Signature of parent or guardian (if applicable)	
Name (printed)	