Eastern Blood Group
HAEMATOLOGY & BLOOD CANCER

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# Patient Registration Form

Please complete all fields.

## Patient Details:

Title: _____ First Name: _____ Last Name: _____

Date of Birth: _____ Occupation: _____

Address: _____

City: _____ State: _____ Postcode: _____

Mobile Phone No. _____ Do you agree to receive SMS reminder notifications: Y / N

Home Phone No. _____ Email: _____

Medicare Card No. _____ Ref No. (number in front of patient's name): _____ Expiry: _____

Private Health Insurance: Y / N Fund Name: _____ Member no. _____

Veteran Affairs (if applicable): Gold / White Card No. _____ Expiry: _____

## Next of Kin:

Full Name: _____ Relationship: _____

Mobile Phone No. _____

## Referring Doctor:

Referring Doctor's Name: _____

Referring Doctor's Address: _____

Contact Number: _____

GP's Name (if different from the above mentioned): _____

GP's Address: _____

## Privacy Statement:

I agree to allow all the doctors listed above to pass on my personal details and medical information to other doctors, hospitals, and medical services who will be involved in my medical management, or to review my pathology and radiology results with other diagnostic specialists through this practice. I also agree to allow him/her to obtain my medical record from any other medical practitioner.

Signature: _____ Date: _____