# Eastern Oncology

Please print clearly in Block Letters **CONFIDENTIAL INFORMATION** To be incorporated into your *history.*

Prof ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐

Patient's Name:

First Name | Preferred Name | Middle Name | Surname

D.O.B: ____ / ____ / ____ (Day / Month / Year)

Occupation:

Address:

City/Suburb:

Post Code

Home Telephone:

Mobile:

Email Address:

DVA Member: Yes ☐ No ☐

Department of Veteran Affairs Number:

Gold Card: ☐ White Card: ☐

Pensioner: Yes ☐ No ☐

Pension Number:

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Reference Number: ___

Expiry Date: ____ / ____ (Month / Year)

Private Insurance: Yes ☐ No ☐

Private Health Fund:

Membership Number:

Next of Kin:

Relationship:

Mobile Number:

Next of Kin:

Relationship

Mobile Number:

Referring Doctor:

Date of Referral: ____ / ____ / ____ (Day / Month / Year)

General Practitioner: (Local Doctor)

Address:

Telephone Number:

Known Allergies: Yes ☐ No ☐

List Known Allergies:

Do you have Advanced Care Plan: Yes ☐ No ☐

Do you have Power of Attorney: Yes ☐ No ☐

## PRIVACY STATEMENT

I agree to allow Eastern Oncology to pass on my personal details and medical information to other doctors, hospitals and medical services who will be involved in my medical management through this practice or to review my pathology and radiology results with other diagnostic specialists. I understand that my de-identified medical information may be used for ethically approved audit/research purposes. I also agree to allow the doctor to obtain my medical record from any other medical practitioner.

**SIGNED**..... Patient **DATE** ____ / ____ / ____ (Day / Month / Year)