

Prof	Dr	Mr	Mrs	Ms	Miss	Mast	A/Prof
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	Department of Veteran Affairs Number:			Gold Card: White Card:	Pensioner: Yes	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 an Advanced Care Plan: Yes No				Do you have a 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

Email to: reception@easternoncology.com