GEELONG HAEMATOLOGY
Blood & Cancer Specialists

Dr Helen Fairweather
Dr Sumi Ratnasingam
Dr David Routledge
Dr Hannah Rose

New Patient Registration

Patient Name:

First Name | Last Name

Address:

Suburb | State | Postcode

DOB: | Home Phone: | Mobile:

Email Address:

Medicare Number: | Ref No.: | Expiry Date:

Health Insurance Fund: | Membership No.: | Level of Cover:

Pension/Healthcare Card No. | Expiry Date | DVA Card No.

Next of Kin: | Relationship to Patient: | Next of Kin Contact No.:

Usual GP: | GP Address:

Consent to Collect Patient Information

We require consent to collect information including your personal details and medical history so that we may properly assess, diagnose and treat medical conditions, and be proactive in your health care. We will also use the information you provide for:

- administrative purposes;
- billing purposes, including compliance with Medicare and Health Insurance Commission requirements; and
- disclosure to others involved in your care, including doctors and specialists outside this practice, in consultation with you.

I have read the statement above and understand why my personal information must be collected. I understand that I am not obliged to provide the information requested, but that failure to do so could compromise health care quality and delivery.

I am aware of my right to access the information collected about me, except in circumstances where access might legitimately be withheld. I accept that in such circumstances an explanation will be offered to me.

I consent to the handling of my information by this practice for the purposes set out above.

Patient Signature: | Date:

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Patient Information

Patient Name:

First Name	Last Name

Past Medical and Surgical History

Problem	Date Diagnosed

Past Family Medical History

Relative	Condition

Social History

Smoking Status	Current smoker	☐	Ex-smoker	☐	Never smoked	☐
Alcohol Consumption	Consume alcohol	☐	Ceased alcohol	☐	Never consumed alcohol	☐
Living Arrangements	Living alone	☐	Spouse, family, other	☐	Assisted living	☐

Drug History

Medicine *e.g. Paracetamol*	**Dose** *1000mg*	**Frequency** *Four times per day when needed*

Any Allergies?		**Medicine**	**Reaction**
Yes ☐	No ☐		