melbourne haematology

new patient form

1

personal details

CONFIDENTIAL

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other

Date of Birth: _____/_____/___________

- **Surname:** ______________________ **Given Name:** ______________________

Address: ______________________

Suburb: ______________________ **Postcode:** ______________

Email: ______________________

Occupation: ______________________

or School Year: ____________ **or University Year and Course:** ______________________

- **Telephone Numbers:** Home: ______________________

Work: ______________ Mobile: ______________ Emergency: ______________

- **Next of kin details** (family member or friend / medical power of attorney)

Name: ______________________ Relationship to you: ______________________

Contact number: ______________________

claim details

- **Medicare Number:** ______________________ Ref No: ________ Exp Date: ______________

Private Health Insurance: ☐ Yes ☐ No Fund Name: ______________ Fund Number: ______________

Concession Cards:

Aged or Disability Pension No: ______________________ Exp Date: ______________

Dept. Veterans Affairs Card No: ______________ ☐ White ☐ Gold Exp Date: ______________

Health Care Card No: ______________________ Exp Date: ______________

- **Usual GP Name:** ______________________ GP Provider Number: ______________

Practice details: ______________________

please turn overleaf

 © 2012 Melbourne Haematology

melbourne haematology

2

new patient form

medical history

- **Do you have or have you previously had any Allergies or Reactions to the following:**

☐ Medications ☐ Tapes ☐ Ointments ☐ Latex

Please provide details: ____

____

- ***If Female* - Are you currently pregnant?** ☐ Yes ☐ No If yes EDD ____________________
- **Do You Have Any Notable Medical Conditions?** ☐ Yes ☐ No

(eg. blood clot in the leg, blood clots in the lungs, diabetes, asthma, high blood pressure, heart attack, angina, epilepsy).

Please Specify: ____

____

- **Are you currently taking any medication to thin the blood?** (eg. Asprin, Warfrin, Plavix or Vitamins) ☐ Yes ☐ No
- Please List: ____

Are you a smoker? ☐ Yes ☐ No If yes, how many per day? ____________________

privacy & consent

The information we collect is used for the primary purpose of providing quality healthcare and may be utilized in the following ways:

- Administrative purposes connected to the running of our practice.
- Billing purposes, including compliance with Medicare and HIC requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside of this practice. This may occur through referral to other doctors or for medical investigations and in the reports or results returned to us following referrals. We will also send results to your referring doctor.

All patients attending this practice have a general right to request access to their own medical record.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I acknowledge that I have read this information before signing and that a member of this practice has, at my request, clarified any aspect of it I did not understand.

Signature: ______________________________ **Date:** ___/___/_________

Name: *(Please Print)* ____

referral source

How did you hear about Melbourne Haematology or the Consultant Haematologist you have come to see?

Referred by Doctor: ☐ GP or ☐ Specialist ____________________

☐ Website – www.melbournehaematology.com.au ☐ Google

☐ Yellow Pages ☐ White Pages ☐ Personal recommendation: ____________________

☐ Other: ____________________

[Form Last Updated March 18, 2012

 © 2012 Melbourne Haematology