AUCKLAND RADIATION ONCOLOGY

Ph: 09 623 6046 Email: reception@aro.co.nz

Full Legal Name: (Last Name) (First Name)

NHI: DOB:

Gender:

PATIENT REGISTRATION FORM

Date: / /

Title: (please circle) Mr Mrs Ms Miss Dr Other Preferred Name:

NZ Residential Address:

NZ Postal Address: (if different from above)

NZ Phone: Home: ( ) NZ Work: ( ) NZ Mobile: ( )

Occupation: Email:

Marital Status: Ethnic Group:

NZ RESIDENT: Y ☐ N ☐ Country of Birth:

Do you require an interpreter: Y ☐ N ☐ Language:

If visiting from overseas, home address in country of residence:

Phone: Home: ( ) Mobile: ( )

Emergency Contact Person / Next of Kin

Name:

Gender: Relationship to Patient:

Residential Address:

Phone: Home: ( ) Work: ( ) Mobile: ( )

Alternative Contact Person / Next of Kin

Name:

Gender: Relationship to Patient:

Residential Address:

Phone: Home: ( ) Work: ( ) Mobile: ( )

Family Doctor

Doctor's Name:

Medical Centre Address: Post Code:

Phone: ( ) Fax: ( )

AUCKLAND RADIATION ONCOLOGY

Full Legal Name: (Last Name) (First Name)

NHI: DOB:

ARO

Radiation Oncologist:

Have you been a patient at ARO before?: Y ☐ – Year: N ☐

Payment Details

How will your treatment be paid for? (tick and complete as many as apply)

1. ☐ Health Insurance

   Name of Health Insurer: Policy Type:

   Membership No.:

2. ☐ Other (ie. Self Funding/Government Agency) Details:

3. ☐ Payment will be made by: credit card ☐ EFTPOS ☐ bank deposit ☐

   other: ☐

- If you have no insurance, you will be required to pay a deposit equivalent to the estimated cost of the treatment course. We strongly recommend you contact ARO for an estimate of costs.
- I understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report.
- I agree I am responsible and will pay for all costs incurred in connection with my treatment.
- I understand that ARO may notify a credit reporting agency and/or instruct a debt collection agency should I default on any payment due by me to ARO.
- I understand that any collection and/or legal costs incurred in recovering any debt will be charged to me.

Personal Property

- I understand and agree that ARO is not, and will not, be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which I may bring to the centre.

Privacy Information

☐ I consent to ARO sharing relevant information that is related to my healthcare and as required by third parties such as Health Insurers, Medical Specialists, ACC, and for quality and audit purposes. I also understand that relevant information will be shared with the appropriate DHB to facilitate my ongoing care. The method of sharing information may be electronic or in hard copy.

- To the best of my knowledge the information I have supplied to ARO is correct.

Print name in full: Signed:

Date: / /

If not the patient, state relationship to patient: