

Name: \_\_\_\_\_  
(Last Name) (First Name)

NHI: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender: Male  Female  Date: \_\_\_\_\_

## PATIENT REGISTRATION FORM

Title: (please circle) Mr Mrs Ms Miss Dr Other \_\_\_\_\_

Marital Status: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

NZ RESIDENT: Y  N  NHI: \_\_\_\_\_

Residential Address: \_\_\_\_\_

Postal Address: (if different from above) \_\_\_\_\_

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

Ethnic Group: \_\_\_\_\_

Do you require an interpreter: Y  N  Language: \_\_\_\_\_

If visiting from overseas, address while staying in NZ: \_\_\_\_\_

Phone: ( ) Occupation: \_\_\_\_\_

### Emergency Contact Person

Name: \_\_\_\_\_

Gender (please circle): Male Female Relationship to Patient: \_\_\_\_\_

Residential address: \_\_\_\_\_

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

### Family Doctor

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( )

### ARO

Oncologist: \_\_\_\_\_

Have you been a patient at ARO before?: (please circle) Y  – Year: \_\_\_\_\_ N

Do you have one of the following prescription cards?: (please bring your card with you)

High Use Health Card: \_\_\_\_\_ Expiry Date: / /

Community Services Card: \_\_\_\_\_ Expiry Date: / /

Prescription Subsidy Card: \_\_\_\_\_ Expiry Date: / /

Other: \_\_\_\_\_ Expiry Date: / /

## 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.: \_\_\_\_\_

Prior Approval No.: \_\_\_\_\_

2.  Payment will be made by: credit card

cheque

cash

EFTPOS

other:  \_\_\_\_\_

3.  Overseas or local agency contact?

- 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.
- 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: \_\_\_\_\_