

Dr Ian Bilmon
Consultant Haematologist
New patient registration form

Name: _____
Title: _____ Given names: _____ Surname: _____

Preferred name : _____

Residential Address: _____
Postcode: _____

Postal address: _____
(if different to above)
Postcode: _____

Date of birth: _____ Email: _____

Preferred telephone: _____ Alternate number: _____

Medicare number: - -

Medicare card reference: Valid to (mm/yyyy): _____

Tick if Medicare ineligible:

Are you a member of a Health Fund? Yes No

Fund name: _____ Member number: _____

Do you have a pension card? Yes No

Pension card number: _____ Expiry: _____

Veteran's affairs file number: _____ Gold White Orange

NB: Please present all relevant cards to reception upon completion

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Next of kin name: _____ Relationship to you : _____

Preferred telephone: _____ Alternate contact: _____

Referring Doctor Details:

Name of referring doctor: _____

Name of usual GP: _____
(if different to above)

Address of GP: _____

Phone no. of GP: _____ Fax no. of GP: _____

Dr Ian Bilmon

Privacy act consent form

Prior to your personal information being collected we are obliged to have you read and sign this consent form. The information which you provide is necessary to properly and effectively assess and treat your medical condition. This information will be stored on the Practice computer system. The information will be accessed only by the treating physician and their employees.

This personal information may also be passed on to other doctors and health professionals who are involved in your care. Your information may also be used in collaboration with other Health Care Providers to coordinate and plan your treatment through a multidisciplinary approach, such as presentation at a Multidisciplinary Meeting.

In addition, there are other circumstances when information has to be disclosed. These include: emergency situations; by Law; to fulfill medical indemnity insurance obligations; to Medicare or private health fund for billing purposes.

Your health information will not be used for any other purposes without your consent. Some of this information (i.e. your name, address, and contact details), together with a copy of outstanding invoices, may be released to a third party for assistance in settling long overdue accounts. You would be advised in writing prior to this action being taken.

Signing this form indicates you understand the above and consent to supply personal information and for it to be used as outlined above.

Name: _____

Date: _____

Signature: _____

Please note payment is required at the end of each consultation.

Payment is accepted in cheque, credit card, or eftpos. We do not accept cash. If Medicare have your bank details then the Medicare rebate can be claimed at the time of your appointment.

Further information regarding privacy can be obtained from the website www.privacy.gov.au