AUCKLAND RADIATION ONCOLOGY
A partnership between MercyAscot and Southern Cross Hospitals
Ph: 09 623 6046 Email: reception@aro.co.nz

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

NHI: DOB:

Gender: Male ○ Female ○

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 (please circle): ○Male ○Female Relationship to Patient:

Residential Address:

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

Alternative Contact Person / Next of Kin

Name:

Gender (please circle): ○Male ○Female Relationship to Patient:

Residential Address:

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

Family Doctor

Doctors Name:

Medical Centre Address: Post Code:

Phone: ( ) Fax: ( )

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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 ○ cheque ○ cash ○

   EFTPOS ○ 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.
- 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: _____