MR 100

Western Private Hospital

PATIENT REGISTRATION

Attach patient identification label

UR No: ..... Admission No: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Patient Details

Specialist	**Diagnosis**
Admission Date ____/____/_____ ☐ **Same Day Admission** ☐ **Overnight Admission**	**Procedure**

OUR ADMISSION STAFF WILL CONTACT YOU PRIOR TO YOUR ADMISSION REGARDING ANY OUT OF POCKET EXPENSES AND TO CONFIRM YOUR TIME OF ADMISSION

PATIENT DETAILS

Title Surname	Maiden Name	
Given Names	D.O.B.	Sex ☐ Male ☐ Female
Address		Post Code
Postal address		Post Code
Telephone (Home)	Telephone (Work)	Mobile
Email address		
Marital Status ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed		
Country of Birth	If Australia, Name State	Resident of Australia ☐ YES ☐ NO
Are you of Aboriginal / Torres Strait Islander (TSI) Origin? ☐ YES ☐ NO	If YES (please circle) Aboriginal / Torres Strait Islander (TSI) / Both	
Interpreter Required ☐ YES ☐ NO	Preferred Language	
Religion		☐ Consent for Clergy Visit

PERSON TO CONTACT

Next of Kin	Relationship	Tel (H)	Mobile
Second Contact	Relationship	Tel (H)	Mobile

LOCAL DOCTOR - Your GP may be notified of your admission. Do you agree? ☐ Yes ☐ No

Usual GP	Telephone
Address	

REFERRING DOCTOR (The Doctor who referred you to your specialist for this admission)

Name	Telephone
Address	
Pharmacy Name	Telephone

PREVIOUS HOSPITALISATION

Have you ever been a patient at Western Private Hospital before? ☐ YES ☐ NO If YES - When? (year)

Have you been hospitalised within 7 days prior to this admission? ☐ YES ☐ NO

If YES - Which hospital?	Dates:

MEDICAL RECORDS AND PRIVACY

Records will be kept of your condition and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law. Western Private Hospital complies with the Privacy Act 1988, including the way in which we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our Hospital (eg. to your health fund, DVA, the Supplier / manufacturer of your prosthesis, to our insurer, your local doctor).

A full version of our Privacy Policy is available on our website: http://westernprivatehospital.com.au/patients-visitors/privacypolicy/

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

TO BE COMPLETED BY PATIENT

PATIENT REGISTRATION

MR 100

BINDING MARGIN – DO NOT WRITE IN THIS AREA

Western Private Hospital

FINANCIAL INFORMATION

Attach patient identification label

UR No: ..... Admission No: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Patient Details

MR 100

PERSON RESPONSIBLE FOR ACCOUNT		
Title Surname	Given Name/s	
Address		Postcode
Telephone (Home)	Telephone (Work)	Mobile
Email address		

ENTITLEMENTS		
Medicare No. ☐☐☐☐☐☐☐☐☐☐ Number next to patient name ☐ Valid to ☐☐ / ☐☐☐☐	Pension No.	Expiry Date
	Health Care Card No.	Expiry Date
	Ambulance No.	Expiry Date
Safety Net Card ☐ YES ☐ NO	Card No.	
Veterans Affairs VX No.	DVA Card Colour Gold / White	

How will this admission be claimed? - please tick	
☐ Private Health Insurance - Please complete section A	☐ Repat/Veterans Affairs - Please complete ENTITLEMENT section
☐ Workcover - Please complete section B	☐ Uninsured/Travel or Overseas Insurance - Please contact us on 9318 3177 for an estimate of your hospital costs. - These costs are payable on admission
☐ TAC or Third Party - Please complete section C	

SECTION A: Private Health Insurance		
Health Insurance Fund	Table / Level of Cover	
Membership No.	Date Joined	Date Paid to
Excess	Excess paid this year	Co-payments

Western Private Hospital recommends that you confirm your level of cover with your health fund prior to your admission to ensure that you are covered for this admission and any procedure performed. Certain levels of cover have out of pocket costs that patients are required to pay for their hospitalisation.

These costs not covered by your health fund are payable on admission. Any additional fees (ie. pharmacy) are payable on discharge.

SECTION B: Workcover	
Employers Name / Address	
Contact Person at Workplace	Telephone
Date of Injury	
Name of Work Insurance Co.	Claim Number
Contact Person at Insurance Co.	
Has your claim been accepted by Workcover?	

SECTION C: TAC or Third Party	
Date of Injury	Accident location
TAC Claim Number	Contact Person at TAC
Has your claim been accepted by TAC?	

BINDING MARGIN – DO NOT WRITE IN THIS AREA