



MR 100



Western Private Hospital

PATIENT REGISTRATION

Attach patient identification label

UR No: Admission No:

Surname:

Name:

Date of Birth: Gender:

Dr:

Patient Details

TO BE COMPLETED BY PATIENT

PATIENT REGISTRATION

MR 100

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 Name/s	Preferred Name	D.O.B.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Address			Post Code	
Postal address			Post Code	
Telephone (Home)	Telephone (Work)	Mobile		
Email address				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Country of Birth	If Australia, Name State	Resident of Australia <input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you of Aboriginal / Torres Strait Islander (TSI) Origin? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES (please circle) Aboriginal / Torres Strait Islander (TSI) / Both		
Interpreter Required <input type="checkbox"/> YES <input type="checkbox"/> NO		Preferred Language		
Religion				<input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES - When? (year)
Have you been hospitalised within 7 days prior to this admission?	<input type="checkbox"/> YES <input type="checkbox"/> 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



Western Private Hospital

FINANCIAL INFORMATION

Attach patient identification label

UR No: Admission No:

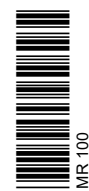
Surname:

Name:

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

Dr:

Patient Details



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PERSON RESPONSIBLE FOR ACCOUNT

Title Surname Given Name/s

Address Postcode

Telephone (Home) Telephone (Work) Mobile

Email address

ENTITLEMENTS

Medicare No. 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

TAC or Third Party - Please complete section C - Please contact us on 9318 3177 for an estimate of your hospital costs. - These costs are payable on admission

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