MR 100

# PATIENT REGISTRATION

*Attach patient identification label*

**Patient Details**

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

Surname: ..........................................................................................

Name: ..........................................................................................

Date of Birth: .......................................... Sex at Birth: ..........................

Dr: ..........................................................................................

TO BE COMPLETED BY PATIENT

| **Specialist** | **Diagnosis** |
|---|---|
| ☐ **Same Day Admission**<br>**Admission Date** ____/____/______ ☐ **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 at Birth ☐ Male ☐ Female ☐ Another Term, please specify

Gender Identity ☐ Male ☐ Female ☐ Other, please specify ☐ Prefer not to answer

Preferred Pronoun ☐ he/him ☐ she/her ☐ they/them ☐ Other, please specify

| 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?<br>☐ YES ☐ NO | If YES (please tick)<br>☐ 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**

BINDING MARGIN – DO NOT WRITE IN THIS AREA

PATIENT REGISTRATION

MR 100

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WPH Western Private Hospital

# FINANCIAL INFORMATION

*Attach patient identification label*

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

Surname: ....................................................................................

Name: ....................................................................................

Date of Birth: .................................... Sex at Birth: ..........................

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 |
| ☐ TAC or Third Party - Please complete section C | ☐ Department of Defence. DAN No.______________________ |

## 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