ST VINCENT'S HEALTH AUSTRALIA

PATIENT REGISTRATION FORM

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: ____________ ADM No: ____________

SURNAME: ____________

GIVEN NAMES: ____________ SEX: ______

DATE OF BIRTH: ____________ PHONE No: ____________

ADDRESS: ____________

TO BE COMPLETED BY CONSULTING ROOMS

Admission Date: ____________ Admission Time: ____________ Overnight + ☐ Day Stay Only ☐

Procedure/Operation: ____________ Date: ____________

Admitting Doctor : ____________ Preferred Accommodation: Shared ☐ Private ☐

Anaesthetist : ____________ Other Medical Practitioners: ____________

PERSONAL DETAILS TO BE COMPLETED BY PATIENT

PLEASE ENSURE WE RECEIVE THIS PAPERWORK 7 DAYS PRIOR TO YOUR ADMISSION

Have you previously been a patient at St Vincent's Private Hospital, ☐ Yes ☐ No

Have you been a patient in any other hospital within the last 28 days: ☐ Yes ☐ No Which Hospital? ____________

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mstr ☐ Sr ☐ Fr ☐ Br ☐ Dr ☐ Other ______

Surname: ____________ Previous Surname: ____________

Given Names: ____________

Address: ____________ Suburb: ____________ Postcode: ______

Phone No (Home): ____________ (Work): ____________ (Mobile): ____________

☐ Are you willing to receive an SMS from the hospital

Sex ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age ______ Marital Status: ____________

Religion ____________ Country of Birth: ____________ Which state?: ____________

Aboriginal/Torres Strait Islander: Yes No Language Spoken ____________

Medicare Number ☐☐☐☐ - ☐☐☐☐☐ - ☐ ☐ Reference number (left of patient name)

Medicare Expiry Date: ______/______ Pension/Health Care Card No.: ____________

DVA - Veterans Affairs No.: ____________ ☐ Gold ☐ White Safety Net No.: ____________

Ambulance Membership ☐ Yes ☐ No Membership No.: ____________

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for your account?

☐ Private Health (see below) ☐ Uninsured ☐ DVA

☐ Workcover (see over) ☐ TAC (see over)

PRIVATE HEALTH INSURANCE

Fund: ____________ Membership No.: ____________

DOCTOR DETAILS

Name of GP: ____________

GP Address: ____________

GP Phone No: ____________ GP Fax No: ____________

SVPHM
P32
09/16

PLEASE TURN OVER

PATIENT REGISTRATION

MR1