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: _____

PLEASE TURN OVER

PATIENT REGISTRATION MR1

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PATIENT REGISTRATION

NEXT OF KIN - FIRST CONTACT

Surname: _____ Given Name: _____ Relationship to patient: _____

Address: _____ Suburb:_____ Postcode:_____

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

ADDITIONAL CONTACT PERSON

Surname: _____ Given Name: _____ Relationship to patient: _____

Address: _____ Suburb:_____ Postcode:_____

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

MEDICAL POWER OF ATTORNEY

Surname: _____ Given Name:_____

Address _____ Phone No: _____

Do you have an Advanced Care Directive? ☐ **Yes** ☐ **No**

WORKCOVER

Name of Employer _____

Address: _____ Suburb:_____ Postcode:_____

Phone No: _____ Date of Accident _____

Has Employer accepted liability? ☐ Yes ☐ No If yes, attach acceptance letter

Has an Insurance Company accepted liability for admission? ☐ Yes ☐ No

Name of Insurance Company: _____ Claim Number_____

Case Manager: _____ Phone No:_____

TAC

Date of accident: _____ TAC Claim No:_____

Support Co-ordinator / Rehabilitation Officer: _____

If you have ticked Work Cover or TAC please note:

Approval of your application is necessary prior to admission. The TAC or Work Cover will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and they have accepted liability for your hospitalisation, treatments and other associated costs.

If TAC or Work Cover do not accept liability for your hospitalisation, treatments and other associated costs, then you may be admitted under your private insurer.

DECLARATION CONCERNING CLAIM (The accurate answers to these questions are an essential part of this claim)

Patient/Guardian to complete (please tick (✔) below)	**Yes**	**No**
Do you have entitlement to claim compensation or damages (including previous settlements)?	☐	☐
Have you lodged a claim for compensation or damages?	☐	☐
Did the injury or condition occur at work, going to or from work or as a result of being at work?	☐	☐
Did the hospitalisation result from a motor vehicle accident?	☐	☐
Did the hospitalisation result from any other type of accident?	☐	☐
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	☐	☐
Is the patient a full-time student dependant over 17 years and under 25 years?	☐	☐

If yes, name of educational institution: _____

Date patient was first aware of symptoms: / / Date patient first consulted a doctor for symptoms: / /

☐ **I hereby declare and warrant that all the above information provided in connection with this claim is true and correct.**

☐ **I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.**

☐ **I authorise my health fund to pay benefits directly to the hospital.**

Patient's/ Guardian's Signature: _____ **Date:** / /

MR1