StVincent's LISMORE

PATIENT REGISTRATION FORM

To be completed by the patient (or support person) and returned immediately to confirm your booking

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

PATIENT DETAILS

Title: (please circle) Mr / Mrs / Ms / Miss / Dr /	Phone (Home):
Surname:	Phone (Work):
Previous Surname:	Phone (Mobile):
Given Names:	May we leave a voice message / SMS alert? ❑ Yes ❑ No ❑ N/A
Gender: ❑ Male ❑ Female	Email:
Date of Birth:	Marital Status: ❑ Single (never married) ❑ Married ❑ Defacto ❑ Widowed ❑ Divorced ❑ Separated
Residential Address:	
	Occupation:
Suburb: Post Code:	Religion:
Postal Address (if different from above):	Country of Birth:
	Indigenous Status: ❑ Aboriginal ❑ Torres Strait Islander ❑ Both ❑ Not Applicable
Suburb: Post Code:	
Have you been a patient at St Vincent's before? ❑ Yes ❑ No	Preferred Language:
Have you been a patient in any hospital within the last 28 days?	Interpreter Required: ❑ Yes ❑ No
This Hospital: ❑ Yes ❑ No Other Hospital: ❑ Yes ❑ No	Are you an Australian Resident? ❑ Yes ❑ No

MEDICAL OFFICER DETAILS

Admitting Doctor:	Local Doctor:
Date of Surgery: Admission Date:	Address:
Referring Dr:	Suburb: Post Code:
Address:	Phone: Fax:

MEDICARE CARD DETAILS

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Reference No. ☐ (in front of your name on the card) Exp: ...../.....

CONCESSION CARD DETAILS

Do you have any type of pension/concessional benefits card?

❑ No ❑ Health Care Card ❑ Pensioner Concession Card ❑ Commonwealth Seniors Card

Benefit Card No: Benefit Card Expiry date: / /

Have you reached the PBS Safety Net for Pharmaceuticals? ❑ Yes ❑ No

Type of Card: ❑ SN Entitlement Card Card No: SN .....

❑ CN Concessional Card Card No: CN .....

DVA Card No: DVA Card Colour (please circle): Gold / White / Orange

Details of cover (white card only):

HEALTH INSURANCE DETAILS

If using Private Health Cover, please confirm these details with your Fund prior to completion

Insurance Type: ❑ Private Health Fund ❑ Self Funded

Health Fund: Table:

Membership No: Do you have an excess or co-payments? ❑ Yes ❑ No Amount: $.....

Have you changed your level of insurance cover in the last 12 months? ❑ Yes ❑ No

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BINDING MARGIN – DO NOT WRITE

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NEXT OF KIN / EMERGENCY CONTACT 1

Name:	Relationship to patient:
Address:	Phone (Home):
	Phone (Work):
Suburb: Post Code:	Phone (Mobile):

NEXT OF KIN / EMERGENCY CONTACT 2

Name:	Relationship to patient:
Address:	Phone (Home):
	Phone (Work):
Suburb: Post Code:	Phone (Mobile):

ADVANCED HEALTH DIRECTIVE / ENDURING POWER OF ATTORNEY

Do you have a current Advance Health Directive? ❑ Yes ❑ No

Do you have enduring power of attorney – health and medical guardian? ❑ Yes ❑ No

Name: Relationship: Phone:

WORKERS COMPENSATION / THIRD PARTY

Written approval will be required prior to admission

Claim No.:	Date of Injury/Accident:	
Employer:	Phone No.:	Fax No.:
Address:	Suburb:	Post Code:
Insurance Company:	Phone No.:	Fax No.:
Address:	Suburb:	Post Code:
Contact Person:		

ACCOMMODATION PREFERENCE

St Vincent's cannot guarantee your accommodation preference will be granted as room allocations are based on availability and clinical need

Room Preference: ❑ Shared room ❑ Private room (please be aware that a copayment may be required for a private room)

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the following information:

❑ Patient Information Booklet ❑ Australian Charter of Healthcare Rights ❑ St Vincent's Privacy Policy

❑ *I do not wish to receive information about the Hospitals services and activities, including fundraising appeals*

Patient's Signature: ..... **Date:** .....

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following: ❑ Informed Financial Consent ❑ Payment Information

Person responsible for payment of accounts to sign here:

Name: ..... Signature: ..... Date: .....

Has this form been completed by the patient: ❑ Yes ❑ No

If No, your name: ..... Contact No.: .....

OFFICE USE ONLY

Table:	Membership Financial ❑ Yes ❑ No	Date:
Excess:	Eligibility Confirmed ❑ Yes ❑ No	Signature:
Co-Payment:	Estimate of Costs $	UR No.:
Table joining date:	Patient notified ❑ Yes ❑ No	Admission No.:

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