Women and Newborn Health Service
King Edward Memorial Hospital

PATIENT REGISTRATION

Med Rec. No: .....

Surname: .....

Forename: .....

Gender: ..... D.O.B. .....

AFFIX LABEL HERE

PLEASE COMPLETE BOTH SIDES OF THIS FORM:

PATIENT: Date:_____

Surname:_____ Full Given Names:_____

Residential Address:_____ Home Phone No.:_____

_____ Work Phone No.:_____ Mobile:_____

Postal Address:_____ Email Address:_____
(if different to residential)

_____ Medicare No.:_____

Birth Date:_____ M/C Ref. No.:_____ EXP Date:_____

Occupation:_____ Repatriation No.:_____

Safety Net No.:_____ Pension/Concess. No.:_____ Exp Date:_____

Carer:_____ Do You Have Private Health Insurance? ☐ Yes ☐ No

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Defacto ☐ Unknown

Maiden Name:_____ Religion:_____

Country of Birth:_____ Ethnicity:_____
(eg: Caucasian, Asian)

Are you (tick one): ☐ Aboriginal ☐ Torres Strait Islander (TSI) ☐ Aboriginal and Torres Strait Islander ☐ Other

Interpreter Required: ☐ Yes ☐ No Language Spoken:_____

Have you been hospitalised or worked in a healthcare facility outside of WA within the past 12 months? ☐ Yes ☐ No

If yes, name of hospital and discharge/leaving date:_____

Do you have an Advance Health Directive: ☐ Yes ☐ No

PERSON TO NOTIFY:

Next Of Kin:_____ Relation To Patient:_____

Address:_____ Home Phone No.:_____

_____ Postcode:_____ Work Phone No.:_____ Ext_____

Mobile No.:_____

LOCAL CONTACT:_____ Relationship To Patient:_____
(other than Next of Kin)

Address:_____ Home Phone No.:_____

_____ Postcode:_____ Work Phone No.:_____ Ext_____

Mobile No.:_____

Address in Perth while receiving treatment:_____

_____ Postcode:_____

DO NOT WRITE IN BINDING MARGIN

HCHKEFMR0010

KE107
08/15

PATIENT REGISTRATION
MR010

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FINANCIAL ELECTION: PLEASE READ THE INFORMATION FOR PATIENT FORM FIRST. IT IS ESSENTIAL THAT YOU INDICATE YOUR ADMISSION ELECTION BY MARKING ONE OF THE BOXES BELOW:

☐ Public Patient

☐ Private Patient Health Fund:_____ Membership No.:_____

Private Doctor's Name:_____

☐ Compensable Patient ie Work, Motor Vehicle, Common Law, Armed Defence Forces, Merchant Seaman etc

☐ Department of Veterans' Affairs

☐ Overseas Visitor Passport No:_____ Country of Issue:_____

Visa No.:_____

Patient / Parent / Guardian / Spouse Signature:_____

Person Responsible For Fees: ☐ Self ☐ Parent ☐ Guardian ☐ Workers' Compensation ☐ Spouse ☐ MVIT ☐ Other

Name:_____

Address:_____ Postcode:_____

TRANSFER/REFER FROM ANOTHER MEDICAL FACILITY

Name of Transferring/Referring Hospital/Medical Facility:

_____

Name of the Referring Clinician:

_____

INFORMATION SHARING

I give my consent for King Edward Memorial Hospital to share my information for the purpose of providing continuing care with other health care providers whilst I am an inpatient.

Patient's Signature:_____ Date:_____

GENERAL PRACTITIONER

Full Name:_____

Address:_____

Postcode:_____ Phone No.:_____

Previous Attendances At KEMH? ☐ Yes ☐ No If Yes, Approx. Date:_____

Name (If Different):_____

Clinic:_____

Comments:_____

Patient's Signature:_____ Date:_____

DO NOT WRITE IN BINDING MARGIN