Patient Registration

Tel : 9115 9888
Email : admin@doncasterhospital.com.au
Web : www.doncasterhospital.com.au

Complete forms must be returned to the Hospital 7 days before admission

DONCASTER PRIVATE HOSPITAL

Title Mr/Mrs/Ms/Miss/Master	Given Name: Preferred Name :	Surname:
Address:	Suburb:	Postcode:
Phone No : Mobile No :	Date of Birth (DD/MM/YYYY):	Marital Status:
Email :	Country of Birth: Preferred Language:	
Resident of Australia : ☐ Yes ☐ No	Name of GP : Address of GP :	

Are you [is the person] of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to answer

Medicare No: ***please advise staff if your Medicare card is reciprocal***	Ref No:	Expiry Date:
Private Health Insurance Fund Name: Policy Number: Policy Name : Do You have an excess? ☐ Yes ☐ No Amount:	Ambulance Cover: ☐ Yes ☐ No Number : ***In the unforeseen event that an ambulance is required, please note that it will be at the patient's expense.***	
Department of Veteran Affairs Card : ☐ Gold ☐ White Number :	Work Cover and TAC Insurance Company : Claim Number :	

Next of Kin (NOK) Contact Details (Person taking you home)

Name: Relationship to you: Contact Number:

Emergency Contact Details

Same as above : ☐ Yes ☐ No If not, Please fill below

Name: Relationship to you: Contact Number:

Power of Attorney (A legal document to appoint someone to make decisions on your behalf)

Do you have a Power of Attorney? : ☐ Yes ☐ No If yes, Please fill below

Name: Relationship to you: Contact Number:

Note: In accordance with The Privacy Act 1988, the Privacy Amendment (Enhancing Privacy Protection) Act 2012, and Victorian Privacy Principles, the management of Doncaster Private Hospital would like to inform you that we gather information from you, when you elect to be a patient of the hospital, in order to enable us to provide efficient, safe and effective quality health service to you. Some of the information that we asked from you are needed by government departments which require us to submit information to them as we are registered with the health department as Day Hospital. The information that we gather may be passed on to other health care providers such as pathologists in order to provide the required services for you.

I, _____ give consent to the management of Doncaster Private Hospital to provide information regarding myself to health workers, government and statutory bodies in order to provide efficient, Safe and effective qualify health services to myself and to satisfy government and statutory laws and regulations.

I acknowledge that I have reviewed the information on patient rights provided above and staff were available to answer my questions

Sign : _____ Date : _____

Payment on admission may be made by cash, bank cheque, credit card (Visa, MasterCard) or EFTPOS.

Personal and business cheques are not accepted. Thank you for understanding.