Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
Phone: (03) 9038 1300 Fax: (03) 9038 1309

MATERNITY REGISTRATION FORM

Patient to complete

Unit Record Number: ☐☐☐☐☐☐☐☐

Family Name: ____________________

Given Name: ____________________

Date of Birth ☐☐☐☐☐☐☐☐ Age: ☐

Sex: ☐ **OR** USE LABEL

Admitting Doctor: .... **Estimated due date:** ....

Personal Details

Title: .... Surname: .... Previous Surname (if applicable): ....

Given Names: .... Preferred Name: ....

Address: .... Suburb: .... State:.................. Postcode: ....

Telephone (Home): .... (Business): .... Mobile: ....

Sex: ☐ Male ☐ Female Date of Birth: .... / .... /................. Age: ....

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: .... Religion: ....

Are you an Australian Resident? ☐ Yes ☐ No Country of Birth:.................................. **If Australia, specify state** ....

Are you of Aboriginal/Torres Strait Islander (TSI) descent? ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal and TSI

Person To Contact (Next of Kin)

Name: .... Relationship to patient: ....

Address: .... Suburb: .... State:.................. Postcode: ....

Telephone (Home): .... (Business): .... Mobile: ....

Name: .... Relationship to patient: ....

Address: .... Suburb: .... State:.................. Postcode: ....

Telephone (Home): .... (Business): .... Mobile: ....

Entitlements

Medicare Card No.: |_|_|_|_|_|_|_|_|_|_| Medicare Reference No.: .... Medicare Expiry Date: ....

Pension/Health Care Card No: |_|_|_|_|_|_|_|_|_|_| Expiry Date: ....

Safety Net No.: |_|_|_|_|_|_|_|_|_|_|

Repatriation (DVA) No.: |_|_|_|_|_|_|_|_|_|_| Card colour: ☐ White ☐ Gold ☐ Other ....

Do you have ambulance cover? ☐ No ☐ Yes Membership No.:..

Card Sighted? ☐ No ☐ Yes (Hospital use only)

Previous Hospitalisation

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year: ....

Is this admission for a child? ☐ No ☐ Yes

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes

Which Hospital? ....

Preferred Accommodation

Whilst every effort is made to accommodate your request, we cannot guarantee availability on the day of admission. Please indicate your preferred accommodation below. Note: Veterans' Affairs patients are covered for shared room accommodation only – a separate charge may apply for a single room. Please check level of health insurance cover if requesting a single room

☐ Shared Room ☐ Single Room

MATERNITY REGISTRATION FORM MR001M

GP / Local Doctor

Full name of GP: ....

GP Address: ....

GP Telephone: .... GP Facsimile: .... GP Email: ....

☐ I do **NOT** want information passed on to my GP.

How will this Admission be Claimed (please ✓tick)

☐ Private Health Insurance – Please complete Sections A and B

☐ Repat/Veterans' Affairs – Please complete Entitlements and Section B

☐ Uninsured – Please complete Section B only

Section A: Private Health Insurance

Fund Name: .... Membership No: .... Date Joined: .... /.......... / ....

Has this level of cover changed in the last 12 months? ☐ No ☐ Yes

Type of cover: ☐ Single ☐ Family ☐ Other .... Level of cover (if known) ....

Do you have an excess? ☐ No ☐ Yes Amount $ .... Have you paid an excess this year? ☐ No ☐ Yes Amount $.................

Section B: Person Responsible for Account

Is the Patient responsible for this account ☐ Yes (Go to next section) ☐ No (Complete this section)

Name: .... Relationship to patient: ....

Address: .... Suburb: .... State:................... Postcode: ....

Telephone (Home): .... (Business): .... Mobile:..

Payment of Account – all patients to complete

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge.

I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of person responsible for account: .... Date .... / .... / ....