Masada Private Hospital

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

MEDICAL ADMISSION - EARLY PARENTING CENTRE REGISTRATION

Patient to complete

Unit Record Number: | | | | | | | | |

Admission Number: | | | | | | | | |

Family Name: _____

Given Names: _____

Date of Birth: | | | | | | | | | Age: | | Sex: | |

OR USE LABEL

Patient's email address: _____

BABY DETAILS

☐ My Health Record Opt Out

Surname: _____ Previous Surname (if applicable): _____

Given Names: _____ Preferred Name: _____

Address: _____ Suburb: _____ State: _____ Postcode _____

Parent Telephone (Home): _____ (Business): _____ Mobile: _____

Sex: ☐ Male ☐ Female ☐ Other Date of Birth: ____ / ____ / _____ Age: _____

PERSON TO CONTACT (Next of Kin)

1. Name: _____ Relationship to Patient: _____

Address: _____ Suburb: _____ State: _____ Postcode _____

Telephone (Home): _____ Date of Birth: ____ / ____ / _____ Mobile: _____

Occupation: _____ Religion: _____

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

Are you of Aboriginal / Torres Strait Islander (TSI) origin?

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown ☐ Decline to Answer

Are you of Australian South Sea Islander (SSI) origin? ☐ No ☐ SSI ☐ Not Stated/Unknown ☐ Decline to Answer

2. Name: _____ Relationship to Patient: _____

Address: _____ Suburb: _____ State: _____ Postcode _____

Telephone (Home): _____ Date of Birth: ____ / ____ / _____ Mobile: _____

Occupation: _____ Religion: _____

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

Are you of Aboriginal / Torres Strait Islander (TSI) origin?

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown ☐ Decline to Answer

Are you of Australian South Sea Islander (SSI) origin? ☐ No ☐ SSI ☐ Not Stated/Unknown ☐ Decline to Answer

ENTITLEMENTS

Baby's Medicare No: | | | | | | | | | | Medicare Reference No: _____ Medicare Expiry Date: _____

Parent's Medicare No: | | | | | | | | | | Medicare Reference No: _____ Medicare Expiry Date: _____

Safety Net No: | | | | | | | | | |

Pension/Health Care Card No: | | | | | | | | | | Expiry Date: _____

Repatriation (DVA) No: | | | | | | | | | | Card Colour: ☐ White ☐ Gold ☐ Other: _____

Do you have Ambulance Cover? ☐ Yes ☐ No Membership No: _____

Card Sighted? ☐ No ☐ Yes (Hospital Use Only)

PARENT 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 admission? ☐ No ☐ Yes

Which Hospital? _____

GP / LOCAL DOCTOR

Full name of GP: _____

GP Address: _____

GP Telephone: _____ GP Facsmilie: _____ 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

Health Fund Name: _____ Membership No: _____

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: ____ / ____ / _____

PRIVACY STATEMENT / RIGHTS & RESPONSIBILITIES

☐ I hereby authorise the Hospital to collect, use and disclose my information.
☐ I understand that the hospital **will not** be liable for any valuables I bring to the hospital.
☐ I am aware of my rights and responsibilities per the Australian Charter of Healthcare Rights.
☐ I consent to a visit from a religious representative.
☐ I consent to receive an informal visit from a member of the local veteran community.

Signature of Patient / Guardian: _____ Date: ____ / ____ / _____

Are you happy to be sent a patient satisfaction survey after discharge from the hospital? ☐ Yes ☐ No