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

DERMATOLOGY REGISTRATION FORM

PATIENT TO COMPLETE

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

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

Family Name: _____

Given Names: _____

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

OR USE LABEL

Admission Date: ____/____/_____ **Admission Time: _____:_____**

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 (TS) descent? ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal & 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 (DNA) 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 this admission? ☐ No ☐ Yes

Which Hospital? _____

DERMATOLOGY REGISTRATION FORM MR 001D

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OR USE LABEL

PERSONAL DETAILS

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 C

☐ Repatriation / Department of Veterans' Affairs (DVA) - Please complete Entitlements and Section C

☐ Workcover / Third Party / TAC - Please complete Sections B and C

☐ Uninsured - Please complete Section C only

SECTION A PRIVATE 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 WORKCOVER / TAC OR THIRD PARTY

☐ Workcover or ☐ Third Party or ☐ TAC (Please tick one box)

The approval letter for this admission (from your insurance company / TAC) must accompany this form.

Insurance Company Details: Name of Insurance Company: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: _____ Claim No: _____ Authorised by: _____

Has your insurance company / TAC accepted liability? ☐ Yes ☐ No Please specify reason (if no): _____

Workcover Patients Only - Employer Details: Name of Employer: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Business): _____

Has your employer completed a Report of Injury Form? ☐ No ☐ Yes

Have you completed a Workcover Claim Form? ☐ No ☐ Yes

SECTION C PERSON RESPONSIBLE FOR ACCOUNT

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