Women and Newborn Health Service
King Edward Memorial Hospital

PATIENT REGISTRATION

Med Rec. No: .....

Surname: .....

Forename: .....

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

AFFIX LABEL HERE

Patient Details

Title | Surname

Full Given Names

Gender

☐ Male ☐ Female ☐ Intersex ☐ Indeterminate
☐ Unknown

Date of Birth

/ /

Residential Address (if Overseas patient provide overseas address)

Postcode

Postal Address (if different to above)

Postcode

Home phone number | Work phone number

Mobile phone number

Email

Occupation

Marital Status

☐ Never Married ☐ Married ☐ Divorced ☐ Separated
☐ Widowed ☐ Defacto

Maiden Name

Religion

Ethnicity (eg: Caucasian, Asian)

State or Country of Birth

Do You Identify as (tick one):

☐ Aboriginal ☐ Torres Strait Islander (TSI)
☐ Aboriginal and Torres Strait Islander ☐ Other ☐ Unknown

Interpreter Services Required?

☐ Yes ☐ No (If Yes, which Language required)

Language:

Medicare Details

Medicare Card Number

☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref No ☐

Expiry Date ☐☐ / ☐☐☐☐

Repatriation No:

Pension/Concession No:

Expiry

Safety Net No:

Do you have Private Health Insurance?

☐ Yes ☐ No

Are you a participant of NDIS?

☐ Yes ☐ No

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:

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

Private Health Fund: | Membership No:

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

☐ Department of Veterans' Affairs

☐ Overseas Visitor

Local Address

Postcode

Passport Number: | Passport Country:

Visa Type: | Visa Expiry Date:

Insurance Fund:

Insurance Fund Membership Number:

Person Responsible for Fees / Relationship:

Name:

Address:

Patient Signature:

DO NOT WRITE IN BINDING MARGIN

HCHKEFMR0010

KE107
11/19

PATIENT REGISTRATION

MR010

PLEASE COMPLETE OTHER SIDE OF FORM

Women and Newborn Health Service
King Edward Memorial Hospital

PATIENT REGISTRATION

Med Rec. No: .....
Surname: .....
Forename: .....
Gender: ..... D.O.B. .....

AFFIX LABEL HERE

☐ Overseas Student

Name of School: Student Number:

Local Address:

Passport number: Passport country:

Visa Expiry Date:

Insurance Fund:

Insurance Fund Membership Number:

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

Do you have a Carer or Guardian?
☐ Yes ☐ No

Next of Kin

Title Surname

Given Names Relationship to patient

Residential Address ☐ Same as patient

Postcode

Home phone number Work phone number

Mobile phone number

Emergency Contact (other than Next of Kin)

Title Surname

Given Names Relationship to patient

Residential Address ☐ Same as patient

Postcode

Home phone number Work phone number

Mobile phone number

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 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