Bretonneux Street
Seymour, Vic, 3661
Phone: (03) 5793 6100

Patient Registration

To be completed for all admissions to Seymour Health and forwarded as soon as possible for processing to:

Admissions
Seymour Health,
Bretonneux Street,
Seymour VIC 3661

Admission Date: | **Time:** | **24 hr**

Surgeon: | **Local GP:**

Surname: | Previous Surname: | Title:

Given Names: | Sex: ☐ M ☐ F

Address:

Postcode: | Date of Birth:

Email Address:

Home phone:

Mobile phone:

Work phone:

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

Medicare Number:
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___
Expiry date: ___ ___ / ___ ___

Pension Number:
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___
Expiry date: ___ ___ /___ ___
☐ Health ☐ Disability ☐ Aged

Country of Birth:

If Australia, what State:

Language spoken: | Interpreter required: ☐ Yes ☐ No

Religion:

Aboriginal/Torres Strait Islander Australian:
☐ Aboriginal and Torres Strait Islander Origin
☐ Aboriginal but not Torres Strait Islander
☐ Non-Aboriginal/Non-Torres Strait Islander
☐ Torres Strait Islander but not Aboriginal

Next of Kin (Contact Person 1):
Name: ______________________________
Relationship: _________________________
Address: ____________________________
Home phone: (   ) __________________
Bus Mob: ____________________________

Next of Kin (Contact Person 2):
Name: ______________________________
Relationship: _________________________
Address: ____________________________
Home phone: (   ) __________________
Bus Mob: ____________________________

Re-admission:
Have you been hospitalised in the past twenty eight (28) days? ☐ Yes ☐ No If so, where ______________
Have you been hospitalised in the past seven (7) days? ☐ Yes ☐ No If so, where ____________________
Have you ever been a patient of Seymour Hospital? ☐ Yes ☐ No When (year)___________________

Admission Type:
If your Doctor has requested you to be a private patient for this episode at Seymour Health please ensure you provide the following;
☐ Private → **Health Fund:** ____________________ **Member Number:** _________________
Also complete: ☐ National Private Patient Hospital Claim Form (left front side only)
☐ Patient Election Form and specify Doctor and single/non single room
☐ Medicare Simplified Billing Form if you are eligible (see back of election form)

☐ Public

☐ DVA → DVA Number: ____________________ Card colour: ____________________

☐ TAC → Reference No.: ___________________ Date of accident: _____/______/______

☐ WorkCover →Employer's Business Name: ____
Insurance Company: _____________________Claim No.:_________________

PATIENT REGISTRATION

MR003

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