NSW GOVERNMENT Health

Facility:

CLIENT REGISTRATION

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR005001

CLIENT DETAILS

Have you ever been admitted or attended an outpatient service at a Hospital, Emergency Department or Community Health in this Area Health Service? ☐ Yes ☐ No

Title	**Surname**	**Given Names (in full)**

Have you ever been known by another name? ☐ No ☐ Yes (list please)	**Mother's maiden name**	**Father's surname**

Sex ☐ Male ☐ Female	**Your Date of Birth** / /	**What country were you born in?**	**What hospital were you born in?**

Marital Status: ☐ Married/de facto ☐ Never Married ☐ Widowed ☐ Separated ☐ Divorced

Your Home Address Property Name/House No. Street Name

Suburb, Town or Locality	**Postcode**	**State/Country (if not Australia)**

Home Phone No.	**Work Phone No.**	**Mobile Phone No.**

Your Postal Address if different to home address: ***(Home address MUST also be filled in please)***

Email Address

What language do you speak at home?	**Do you need an interpreter?** ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander Descent? ☐ No ☐ Yes *if yes→* ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

What is your Religion? Withhold religion information from Chaplain Services? ☐ YES	**What is your occupation?**

PERSON FOR NOTIFICATION DETAILS

Who is your contact person	**Relationship to patient**
Address of contact person: ☐ **same as client**	**Contact Phone Numbers**

FINANCIAL DETAILS

Do you have Private Health Insurance? ☐ **No** ☐ **Yes** (please complete following details) Type of Cover: ☐ Single Room ☐ Shared Room ☐ Basic ☐ Extras

Fund Name Fund Number

If you are not in a Private Health Fund, do you choose to be a self-funded Private patient? ☐ **Yes** ☐ **No**

Is your health care covered by Veteran's Affairs? ☐ No ☐ Yes If YES, please complete details

Card Colour: ☐ Gold ☐ Orange ☐ White DVA Card No.: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Single Digit next to patients name: ☐ **Exp Date:**_____

Are you covered by Workers Compensation: ☐ No ☐ Yes	**Solicitor/Employer's Name:**
Are you covered by Third Party: ☐ No ☐ Yes	**Solicitor/Employer's Address:**
Are you an overseas Visitor? ☐ No ☐ Yes	**Solicitor/Employer's Phone Number:**

Who is your local GP?	**Address of GP**	**Phone No**
Who is your referring Doctor?	**Address of Referring Doctor**	**Phone No**

The facility you are attending may have an active programme which gives patients and other interested persons an opportunity to be kept informed about its new developments, learn of progress in clinical areas and to receive information of fundraising activities. ☐ **Please tick this box if you wish to receive this information.**

Staff Name: Date:___/___/____ Arrival Time:_____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH606529 210514

CLIENT REGISTRATION SMR005.001