



# PATIENT REGISTRATION FORM

SURNAME.....GIVEN NAME.....  
ADDRESS .....AFFIX LABEL HERE.....  
MRN .....SEX.....  
DATE OF BIRTH.....

Proposed Date of Admission .....Surgeon.....

## Patient Details

Title.....First Name.....Middle Initial.....Surname.....

Date of Birth.....Country of Birth.....Marital Status.....

Preferred Contact Phone Number .....

Medicare Card 

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 Position Number ..... Expiry Date...../...../.....

Pension/DVA Card 

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 DVA Colour ..... Expiry Date...../...../.....

Safety Net Card 

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Are you: (Please tick appropriate box)

Aboriginal? ☐ Torres Strait Islander? ☐ Aboriginal and Torres Strait Islander? ☐ Neither? ☐

*This information is required under the National Health Information Agreement and is used in monitoring the effectiveness of health policies and programs and highlights any inequalities between various ethnic groups*

## Contact Details

Name and address of your current General Practitioner (GP): .....

### Next of Kin

Name .....Relationship.....

Address.....Phone number.....

### Person to contact in an Emergency (must be available by phone throughout patients procedure)

☐ As Above ☐ Other, Who? Name.....Relationship.....

Address.....Phone number.....

### Planning for Discharge – Please tick the boxes below wherever the answer is yes

☐ I live alone

☐ I have someone to help look after me on discharge.

Who? .....

☐ I anticipate returning home after discharge.

Name of Escort:.....If not I will be staying with .....

Address.....Phone number.....

I declare that I have read and understood the information contained in the Procedure Admission Package

Signature of Patient / Parent / Guardian (if under 18) ..... Date...../...../.....

Patient  
Registration  
Form