Chesterville Day Hospital
Patient Registration Form

Procedure Date ______________

Name of Dr performing procedure ___________________________

PATIENT DETAILS — to be completed by patient or guardian

TITLE [ ] SURNAME [ ] FIRST NAME [ ]

ADDRESS [ ] P/C [ ]

DATE OF BIRTH ____/____/_______ EMAIL: [ ]

HOME PHONE [ ] MOBILE [ ]

MARITAL STATUS: [ ] MARRIED/DEFACTO [ ] NEVER MARRIED [ ] WIDOWED [ ] SEPARATED/DIVORCED

COUNTRY OF BIRTH: [ ] ARE YOU A PERMANENT RESIDENT OF AUST? YES [ ] NO [ ]

LANGUAGE AT HOME? [ ] Are you of Aboriginal/Torres Strait Island descent? YES [ ] NO [ ]

NEXT OF KIN

Person to Contact (Next of Kin) NAME [ ]

Relationship to Patient: [ ] Phone Number [ ]

ACCOUNT DETAILS

Who is responsible for the hospital account? [ ] PATIENT [ ] OTHER - please specify [ ]

Medicare number [ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ] ref no. [ ] Medicare Card Expiry ___/20___

Aged Pension Card : [ ] Vet Affairs Card [ ]

Payment for account is by: [ ] PRIVATE HEALTH INSURANCE [ ] SELF FUNDED [ ] VET AFFAIRS [ ] OTHER

HEALTH FUND [ ] MEMBER NO [ ]

HAVE YOU BEEN WITH YOUR HEALTH FUND **OR** YOUR CURRENT LEVEL OF COVER FOR OVER 12 MONTHS? YES [ ] NO [ ]

Declaration: I have carefully read all of the above and certify that the information I have given is correct and true to the best of my ability. I understand that I must have a responsible adult accompany me home, and that I must not drive for 24 hrs following any sedation or general anaesthetic. I also accept full responsibility for accounts rendered by Chesterville Day Hospital including any shortfall in reimbursement by my health fund.

Signature____Date____________

MEDICAL/LIFESTYLE INFORMATION

Do you have or have you had any of the following conditions? (Please tick if YES) ✔

Diabetes? TYPE _______________ ◯	Liver disease/Hepatitis? TYPE_____	Do you smoke? ◯ Amount/week________
Stroke? ◯	Kidney/Bladder Disease? ◯	Do you drink Alcohol? ◯ Amount/week________
High Blood Pressure? ◯	HIV/AIDS? ◯	Are you vision impaired? ◯
Heart Attack? ◯	Epilepsy/Fits? ◯	Are you hearing impaired? ◯
Chest Pain/Angina? ◯	Breathing problems/Asthma? ◯	Do you have a walker/stick? ◯
Palpitations? Irregular Heart beat? ◯	Motion Sickness? Fainting? ◯	Have you had a fall recently? ◯
Pacemaker? ◯	Do you have Current cold/cough? ◯	Do you have an Advanced Care Directive? ◯
Blood clots in lungs/legs ◯	Sleep Apnoea? ◯	Do you have loose teeth/denture/caps? ◯
Females – Are you Pregnant? ◯	Have you or your family had a history of CJD? ◯	Pressure Ulcers? ◯
Infection or exposure to MRSA/VRE or CRE? ◯	Infectious disease/communicable disease within last 2 weeks? (chicken pox, measles, gastro, other) ◯	Have you returned from overseas in last 4-6 weeks? Or had an overnight stay in an overseas hospital in past 12 months? ◯
Neurological condition? ◯ (Alzheimer's, dementia)		Any other condition? ◯ Details: ___________________________________
Your Height _____________cm or ft	**Your Weight___________ kg**	____

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO MEDICATION, FOODS, LOTIONS, STICKING PLASTERS, LATEX (RUBBER) OR ANY OTHER SUBSTANCES NO ☐ YES ☐ give details ☐

MEDICATIONS

Please list all of your current medications including Vitamins, Natural and Complementary Medicines

Are you on any ANTI COAGULANT or BLOOD THINNING Medications? (e.g. warfarin, Coumadin, plavix, co-plavix,iscover)

NO ☐ YES ☐ Give details ☐

ESCORT HOME

Who will be taking you home from Chesterville Day Hospital? ☐

Relationship? ☐ Phone Number? ☐