

## PATIENT REGISTRATION

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

### PLEASE COMPLETE BOTH SIDES OF FORM:

**PATIENT:**

DATE: \_\_\_\_\_

SURNAME: \_\_\_\_\_

FULL GIVEN NAMES: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE No.: \_\_\_\_\_

\_\_\_\_\_ POSTCODE: \_\_\_\_\_

WORK PHONE No.: \_\_\_\_\_ MOBILE \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MEDICARE No.: \_\_\_\_\_

SAFETY NET No.: \_\_\_\_\_

M/C Ref. No. \_\_\_\_\_ EXP Date: \_\_\_\_\_

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES / NO

**MARITAL STATUS:** NEVER MARRIED / MARRIED / DIVORCED / SEPARATED / WIDOWED / DEFACTO / UNKNOWN

RELIGION: \_\_\_\_\_

PENSION/CONCESS. No.: \_\_\_\_\_ EXP Date: \_\_\_\_\_  
(NAME STATE IF AUSTRALIA)

REPATRIATION No.: \_\_\_\_\_

COUNTRY OF BIRTH: \_\_\_\_\_

MAIDEN NAME: \_\_\_\_\_

MAIDEN NAME RETAINED: YES / NO

INTERPRETER REQ'D: YES / NO

LANGUAGE SPOKEN: \_\_\_\_\_

IS PATIENT OF ABORIGINAL OR TORRES STRAIT ISLAND DESCENT? YES / NO

**PERSON TO NOTIFY:**

NEXT OF KIN: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE No.: \_\_\_\_\_

\_\_\_\_\_ POSTCODE: \_\_\_\_\_

WORK PHONE No.: \_\_\_\_\_ EXT \_\_\_\_\_

MOBILE No.: \_\_\_\_\_

**LOCAL CONTACT:** \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE No.: \_\_\_\_\_

\_\_\_\_\_ POSTCODE: \_\_\_\_\_

WORK PHONE No.: \_\_\_\_\_ EXT \_\_\_\_\_

MOBILE No.: \_\_\_\_\_

PERSON RESPONSIBLE FOR FEES: SELF / PARENT / GUARDIAN / WORKERS' COMPENSATION / SPOUSE / MVIT / OTHER

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

**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 HEALTH FUND: \_\_\_\_\_ MEMBERSHIP No.: \_\_\_\_\_

PRIVATE DOCTOR'S NAME: \_\_\_\_\_

COMPENSABLE PATIENT ie Work, Motor Vehicle, Common Law, Armed Defence Forces, Merchant Seaman etc

DEPARTMENT OF VETERANS' AFFAIRS

OVERSEAS VISITOR PASSPORT No: \_\_\_\_\_ COUNTRY OF ISSUE: \_\_\_\_\_

VISA No.: \_\_\_\_\_

PATIENT / PARENT / GUARDIAN / SPOUSE SIGNATURE: \_\_\_\_\_

**TRANSFER / REFER FROM ANOTHER MEDICAL FACILITY**

NAME OF THE REFERRING/TRANSFERRING HOSPITAL/MEDICAL FACILITY:

NAME OF THE REFERRING CLINICIAN:

**GENERAL PRACTITIONER / FAMILY DOCTOR:**

FULL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POSTCODE: \_\_\_\_\_ PHONE No.: \_\_\_\_\_

HAVE YOU BEEN HOSPITALISED OUTSIDE W.A. IN THE PAST 12 MONTHS? YES / NO

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PREVIOUS ATTENDANCES AT KEMH? YES / NO IF YES APPROX. DATE \_\_\_\_\_

NAME (IF DIFFERENT): \_\_\_\_\_

CLINIC: \_\_\_\_\_

COMMENTS: \_\_\_\_\_