MONASH SURGICAL PRIVATE HOSPITAL

252-256 Clayton Road, Clayton, 3168

Ph: (03) 8545 8000 Fax: (03) 8545 8080

www.msph.com.au

monashsurgical@msph.com.au

OFFICE USE ONLY

U.R. No. ☐☐☐☐☐☐☐☐

Date received ____________

PATIENT REGISTRATION

Please complete this form **in BLACK PEN** and forward to Monash Surgical Private Hospital **PRIOR TO ADMISSION.** If this form will not reach us before your admission please telephone 8545 8000 and give details, or send details (both sides) by fax to 8545 8080.

ADMISSION DATE: ____________ DOCTOR: ____________

PROCEDURE: ____________

PATIENT DETAILS

Surname ____________ Mr/Mrs/Ms/Miss ____ Given Names ____________

Date of Birth ____________ Age ____ Previous Surname (if any, if ex-Patient) ____________

Full Residential Address ____________ Suburb/Town ____________ Postcode ☐☐☐☐

Postal Address if different to above ____________ Suburb/Town ____________ Postcode ☐☐☐☐

Mobile Number ____________ Telephone - Private ____________ Telephone - Business ____________

Email Address ____________ Occupation ____________

Medicare No. & Reference Number listed next to name on card ☐☐☐☐☐☐☐☐☐☐ / ☐ Reference No.

Marital Status ____________ Religion ____________

Country of Birth (State if in Aust.) ____________

Are you of Aboriginal or Torres Strait Islander descent ☐ Yes ☐ No

Do you require an interpreter? ☐ Yes ☐ No If yes, Language Spoken ____________

Language spoken at home ____________

NEXT OF KIN (Person to contact) ____________ Relationship ____________

Address ____________ Suburb/Town ____________ Postcode ☐☐☐☐

Mobile Number ____________ Telephone - Private ____________ Telephone - Business ____________

Email Address ____________

OTHER DETAILS

1. Have you been a patient at Monash Surgical Private Hospital/Monash Day surgery before?

   Yes ☐ No ☐ If yes, when? ____________

2. Have you been discharged from any hospital during the last two weeks?

   Yes ☐ No ☐ If yes, Name of Hospital ____________

3. Do you have any wounds or infections? Yes ☐ No ☐

4. **Do you suffer from Diabetes** **Yes** ☐ **No** ☐ **If Yes** **Type 1** ☐ **Type 2** ☐ **Diet controlled** ☐ **Tablet controlled** ☐ **Insulin required** ☐

5. **Do you have a LATEX Allergy? Yes** ☐ **No** ☐

PATIENT REGISTRATION FORM MR/005

PAYMENT OF ACCOUNT

☐ **NON/SELF INSURED** – (UNINSURED/NO HOSPITAL COVER)

Non-insured Patients are required to **pay their account on admission.**

Fees may be paid by Cash, Eftpos, Mastercard or Visa. **No cheques will be accepted.**

☐ Workers Compensation/WorkCare patient? ☐ Overseas Insurance ☐ Transport Accident Commission patient?

Details ______________________________

☐ Veterans' Affairs patient? Repat Number ______________________________

☐ **PRIVATELY INSURED PATIENTS** – PATIENTS COVERED BY HEALTH INSURANCE

Monash Surgical Private Hospital will claim your entitled benefit directly from your private health fund. **The balance owing after the rebate must be paid on admission.** Your membership details must be completed prior to your admission day. This will enable the hospital to confirm your cover and contact you if need be prior to your hospitalisation.

Fees may be paid by cash, EFTPOS, Mastercard or Visa. **No cheques will be accepted.**

HEALTH FUND DETAILS

Health Fund	Membership Number	Your Full Name Registered with Health Fund

Please confirm the following with your Health Insurance

Do you have a Co-payment? No ☐ Yes ☐ If yes amount $ ________________

Do you have an Excess? No ☐ Yes ☐ If yes amount $ ________________

Have you been in hospital this calendar year? No ☐ Yes ☐ If yes Excess Paid $ ________________

Date you joined your Health Fund ______________________________

Have you completed your Health Funds waiting period for the treatment you are having? No ☐ Yes ☐ if NO please call hospital reception
(eg. IVF and Pregnancy related 12 months)

Have you transferred from another Health Fund? No ☐ Yes ☐ if yes please complete details below.

Previous Health Fund	Membership Number	Years of Membership

IVF

Are you donating your Eggs to another female? No ☐

Yes ☐ if YES are you a *Known Donor* or *Anonymous Donor* (please circle)

For Known Donors please complete

Name of Recipient ____________________ IVF Number ________________

Address ____________________ Phone number ________________

☐ **CHILD/ADOLESCENT PATIENT**

Name of Person paying account ______________________________

Address ______________________________

Phone ______________________________

OFFICE USE ONLY

Name of Fund Personnel ________________ Date Checked ________________ Checked by ________________

Method of check: Internet / Email / Thelma / Phone / Fax Waiting for Fund Confirmation ☐ Date Received ________________

Financial: No PRD Yes ________________ Waiting period served? Yes ☐ No ☐ Initials ________________

NOTES: ______________________________

Co-payment payable $ ________________

Excess payable (Is procedure cost < excess + co-payment?) $ ________________

Exclusions on cover? (eg. basic cover, pregnancy related, waiting period not served) Patient to pay $ ________________

Total payable $ ________________