Women's & Children's Hospital

PATIENT REGISTRATION
PMI Update

COMPLETE PATIENT DETAILS
or AFFIX LABEL

UR Number: ....
Surname: ....
Given Names: ....
D.O.B. .... Sex: ....

Has the patient ever previously attended or were they born at the:
☐ Women's & Children's Hospital ☐ Adelaide Children's Hospital ☐ Queen Victoria Hospital

Previous name (e.g. maiden name): ....

Known as name(e.g. alias): ....

Country of Birth: ☐ Australia ☐ Other ....

Marital Status: ☐ Never Married ☐ Married/Defacto ☐ Widowed ☐ Separated ☐ Divorced

Religion: ....

Language, IF interpreter required: ....

Title: ☐ Mr ☐ Mast ☐ Miss ☐ Ms ☐ Mrs ☐ Dr

Indigenous Status: ☐ Non-Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

If Non-Indigenous, which ethnic origin do you identify as?
(E.g. Australian, Chinese) ....

PATIENT CONTACT INFORMATION

Patient Address	Suburb	P/Code	Contact Phone Numbers
MAILING			Home .... Work .... Mobile ....
Residential if different to MAILING			
Temporary if different to MAILING			If applicable, Temp. Ph ....

Do you wish to be notified via SMS of future appointments: ☐ Yes ☐ No

Type of Usual Accommodation: ☐ House or Flat (private residence) ☐ Other (hotel/motel) ☐ Psychiatric Hospital ☐ No Usual Residence ☐ Homeless (boarding) ☐ Homeless (shelter) ☐ Unknown

CONTACT PERSON 1 (i.e. parents or partner)

Name: ....
Address: ....
.... P/Code ....
Ph (Hm) .... (Wk) ....
Mobile .... Relationship: ....

CONTACT PERSON 2 (i.e. friend or relative)

Name: ....
Address: ....
.... P/Code ....
Ph (Hm) .... (Wk) ....
Mobile .... Relationship ....

GENERAL PRACTITIONER (GP)

Doctor/Clinic: ....
Address: ....
.... P/Code ....
Ph .... Provider No: ....

REFERRING DOCTOR (if not GP)

Doctor/Clinic: ....
Address: ....
.... P/Code ....
Ph .... Provider No ....

FINANCIAL STATUS

Medicare ☐ Eligible ☐ Non Eligible (chargeable)
Card number: ....
Ref No: .... Expiry: ..... / .....

Health Insurance: ☐ Yes ☐ No
Cover: ☐ Hospital ☐ Family ☐ Single
Health Fund Name: ....
Membership No: ....

Concession Card: ☐ N/A ☐ Healthcare ☐ Pension
CRN: .... Expiry: ..... / .....

Dept/Staff requesting ....
Ext/Pager .... Date ....

ATTENDANCE DETAILS

Attendance Reason (E.g. outpatient, admission, pregnancy)
.... Date: ....
Clinic/Dr: ....
If for Pregnancy, Delivery Date: ....

Patient Election: ☐ Private Self-funded (chargeable) ☐ Public ☐ Private Insured (chargeable)

Patient or Parent/Guardian Name: ....
Signature: .... Date: ....

Office Use Only Actioned ☐ PMI ☐ MR2A form
Staff Member: .... Date: ....

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