

ENTITLEMENTS
Medicare / Safety Net / Veterans' Affairs

Medicare Card	Card No	Medicare ID No	Left of name	Expiry
Other Card Type	<input type="checkbox"/> Pensioner Card <input type="checkbox"/> Health Care Card <input type="checkbox"/> C'wealth Senior Card	Expiry		
Safety Net Card	<input type="checkbox"/> Safety Net Entitlement <input type="checkbox"/> Safety Net Concession			

If you have a current Prescription Record Form, please bring this with you to the hospital as you may be eligible for benefits under the Medicare Safety Net Scheme.

If you do not intend to claim your hospitalisation costs through the DVA please complete Medicare Entitlement Section above

Veterans' Affairs	<input type="checkbox"/> Gold <input type="checkbox"/> Orange* <input type="checkbox"/> White	DVA No	* (Pharmaceutical benefits only) Expiry
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White cardholders only: Your doctor must obtain approval from the Department of Veterans' Affairs prior to day of admission

WORKERS' COMPENSATION / PUBLIC LIABILITY / THIRD PARTY PATIENTS ONLY

Date of accident	Name of Insurer at time of accident	Insurer's Claim No.
Insurer's address	P/code	Insurer's fax no. / Phone No.
WCC Cases only	Name of employer	Contact person / Phone no.

PERSON RESPONSIBLE FOR PAYMENT (if other than patient)	Name
Postal address for account (if different to above)	Home Ph
Suburb	P/Code / Work Ph / Mobile

POWER OF ATTORNEY / ENDURING GUARDIAN / ADVANCE CARE DIRECTIVE <i>(a copy of these is required if applicable)</i>	Do you have an Advance Care Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Enduring Guardian (if one appointed)	Phone No.
Name of Power of Attorney (if one appointed)	Phone No.

CONSENT TO USE PERSONAL INFORMATION	I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the section on the San Day Surgery Hornsby Personal Information & Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital. I understand that my contact details may be given to the Sydney Adventist Hospital Foundation. I give consent to the use of my personal information as described in this Pre-Admission booklet. I understand that I may withdraw my consent at any time.
Signature	Print Name / Date

ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES	I have read and understand the section entitled <i>Patients' Rights and Responsibilities</i> in this Pre-Admission booklet and will discuss any queries with staff.
Signature	Print Name / Date

CONFIRMATION OF COMPLETENESS OF FORM	I certify the information on this form to be true & complete to the best of my knowledge.
Signature	Print Name / Date

Recent hospital admission	Hospital admission in the last 6 months (including SDSH) <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which hospital? _____ Reason _____	From _____ to _____ If SDSH, planned admission <input type="checkbox"/> Yes <input type="checkbox"/> No
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