the San DAY SURGERY HORNSBY

Patient ID label

ADMISSION FORM

Family Name .....

Given Name(s) .....

D.O.B. .....

PATIENT TO COMPLETE BOTH SIDES of this form

THIS HOSPITAL VISIT

Date of Admission 2 0

Admitting Dr's Name .....

Initials .....

PERSONAL DETAILS

Have you attended The San Day Surgery Hornsby as a patient before? ☐ No ☐ Yes (under what name).....

Title	Family Name	Given Name(s)

Preferred Name	Previous Family Name (if applicable)	Date of birth	Gender
			☐ Male ☐ Female

Marital Status ☐ Married (including defacto) ☐ Single ☐ Widowed ☐ Separated ☐ Divorced — Home Ph

Unit No.	Street No.	Street Name	Work Ph

Suburb	P/code	Email address	Mobile

Preferred pre-operative contact no.

Postal address same as above ☐ Yes ☐ No

If No, postal address — Suburb — P/code

Sydney Contact No.(s) if not from Sydney

Country of Birth	Country of Residence	Language spoken at home? ☐ English ☐ Other..... Interpreter Required ☐ No ☐ Yes

Indigenous status *(please tick at least one box)* ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither — Occupation — Religion

Usual GP's name	Address	Phone No.
	Suburb / P/code	Fax No. (if known)

PERSONS TO CONTACT

Name — Relationship — Home Ph

Street address (if different to above) — Work Ph

Suburb — P/code — Mobile

Name of other Emergency contact — Contact Phone No.(s)

If you are claiming through the Department of Veteran's Affairs or Workers' Compensation please go to next page

Do you have private health insurance? ☐ No ☐ Yes **If yes, please provide details below**

PRIVATE HEALTH FUND

Fund name	Client / membership No.	Table / type of cover	Relationship of patient to contributor

Contributor's Title	Family Name	Given Name(s)	Home phone No.

Contributor's address if different from patient's personal street address? — P/code

Have you been in this fund / table for over 12 months? ☐ Yes ☐ No

If No, have you transferred from another fund? ☐ No ☐ Yes If Yes, which fund?.....

Patients with less than 12 months membership in their fund / table may not be eligible for any benefits.

Return address: San Day Surgery Hornsby, 1a Northcote Road, Hornsby 2077

ADMISSION FORM

MR 1AAS

MR1AASP1

Family Name	Given Name(s)	D.O.B.	**OFFICE USE ONLY P2 OF MR 1AAS** MRN .....

ENTITLEMENTS
Medicare / Veterans' Affairs

Medicare Card Card No | | | | | | | | | | | Medicare ID No Left of name | | Expiry ___ ___/___ ___

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

Veterans' Affairs ☐ Gold ☐ Orange* ☐ White DVA No | | | | | | | | | * (Pharmaceutical benefits only) Expiry ___ ___/___ ___

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

Type of claim ☐ Workers' Compensation ☐ Third Party motor vehicle ☐ Public Liability

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

ADVANCE CARE DIRECTIVE *(If yes, a copy of this is required)*	Do you have an Advance Care Directive?	☐ Yes			☐ No
ENDURING GUARDIAN *(If yes, a copy of this is required)*	Have you appointed an Enduring Guardian?	☐ Yes	Name	Phone No.	☐ No
POWER OF ATTORNEY *(If yes, a copy of this is required)*	Have you appointed a Power of Attorney?	☐ Yes	Name	Phone No.	☐ 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 ...../...../20.....

ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES

I have read and understand the section entitled *Patients' Rights and Responsibilities* in this Pre-Admission booklet and will discuss any queries with staff.

Signature ..... Print Name ..... Date ...../...../20.....

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 ...../...../20.....

MR1AASP2