

**ROYAL CHILDREN'S HOSPITAL
PATIENT REGISTRATION FORM**

Admissions Phone: 9345 6179
Fax: 9345 6202

Appointments Phone: 9345 6180
Fax: 9345 5034

Please return this form to the R.C.H. as soon as possible to avoid unnecessary delay at time of presentation.

UR No:

PATIENT INFORMATION

Has the patient ever attended this hospital before
 Yes No

Surname
 Given name

Previous Names/Alias/Also Known As: (for cross referencing purposes)

ADDRESS:

 Postcode:

Phone Number:
 Home:
 Work:
 Mobile:

Birth Date:
 / /

SEX
 Male Female

Religion: BAPTISED
 Yes No

Country of Birth:
 (if Australia, specify State)

Aboriginal Descent
 No⁽²⁾
 Yes
 If yes:-
 (5) Aboriginal only
 (6) Torres Strait Islander only
 (7) Both Aboriginal & Torres Strait

Main language spoken at home by parents: Interpreter Required
 Yes No

MEDICARE NUMBER
 - - /
 Number which appears on the card beside the name of the patient ↗

Is the patient a permanent Resident of Australia?
 Yes No

PARENT/S
 Surname:
 Given Name: Country of Birth:
 Relationship:

Surname:
 Given Name: Country of Birth:
 Relationship:

PATIENT'S LEGAL GUARDIAN: (for correspondence purposes)
 Name:
 Address:
 Postcode:
 Relationship:

PERSON FINANCIALLY RESPONSIBLE FOR PATIENT:
 Name:
 Address:
 Postcode:
 Relationship:

PRIVATE INSURANCE DETAILS:
 Fund Name:
 Table Number:
 Membership Number:
 Date Joined:
 Is the Cover subject to an "excess" payment? Yes No
 Level of Cover:
 Top Intermediate Basic Extras

LOCAL DOCTOR'S DETAILS:
 Doctor's Name:
 Address:
 Postcode:
 Phone No.: Fax No.:

Please Complete and Post to:
ADMISSIONS/OUTPATIENTS OFFICE
 Royal Children's Hospital
 Flemington Road, PARKVILLE 3052
 Admission Date: / /