Central Sydney Private Hospital
悉尼中央私立醫院
part of sms centres of surgery

Admissions Office
Level 5, Sussex Centre 401 Sussex Street
Haymarket NSW 2000
Email: bookings@centralsydneyprivatehospital.com.au
Ph: 9281 3822 Fax: 9281 5922

Place ID Label Here

PRE-ADMISSION FORM

To be completed by Patient and forwarded to admission office two weeks prior to admission

Have you been a patient in this Hospital before: ☐ Yes ☐ No

Year _____

Have you been Hospitalised within 7 days prior to this admission:
☐ Yes ☐ No

Which Hospital? _____ Dates: / /

Admitting Doctor: _____

Date of Admission: / /

Date of Operation: / /

Admission Type: ☐ Inpatient ☐ Day Patient

Procedure / Reason for Admission:

_____

_____

PERSONAL DETAILS

Title: Mr., Mrs., Miss., Ms. _____

Surname: _____

Previous Surname (if applicable): _____

Given Names: _____

Preferred Name: _____

Sex: ☐ Male ☐ Female Date of Birth: / / Age:

Marital Status: ☐ Single ☐ Married ☐ De facto
☐ Separated ☐ Divorced ☐ Widowed

Are you an Australian Resident? ☐ Yes ☐ No

Address: _____

Suburb: _____ State: _____

Postcode: _____

Telephone (Home): _____

Mobile: _____

Email: _____

Are you of Aboriginal/Torres Strait Islander (TSI) descent?
☐ No ☐ Yes, Aboriginal ☐ Yes, TSI
☐ Yes, both Aboriginal and TS

Religion: _____

Country of Birth _____ If Australian, specify state _____

Nationality: _____

Language spoken at home: _____

Interpreter Required: ☐ Yes ☐ No

Occupation: _____

PERSON TO CONTACT (NEXT OF KIN)

Name: _____

Relationship to patient: _____

Address: _____

Suburb: _____ State: _____

Postcode: _____

Telephone (Home): _____

Mobile: _____

Email: _____

Second Contact/Enduring Guardian: _____

Telephone: _____

ENTITLEMENTS

Medicare Card Number: _____

Medicare Reference No: _____

Medicare Expiry Date: _____

Pension/Health Care Card Number: _____

Expiry Date: _____

Safety Net Number: _____

Repatriation Number: _____

ROOM PREFERENCE

☐ Shared ☐ Private (when available)

BINDING MARGIN - NO WRITING

MARCH 21

PRE-ADMISSION FORM

MR 3

Central Sydney
Private Hospital
悉尼中央私立醫院
part of sms centres of surgery

Admissions Office
Level 5, Sussex Centre 401 Sussex Street
Haymarket NSW 2000
Email: bookings@centralsydneyprivatehospital.com.au
Ph: 9281 3822 Fax: 9281 5922

Place ID Label Here

PRE-ADMISSION FORM

To be completed by Patient and forwarded to admission office two weeks prior to admission

GP / LOCAL DOCTOR

Full name of GP: _____

GP Address: _____

GP Telephone: _____

HOW WILL YOU CLAIM FOR THIS ADMISSION

(please tick ✔ one box only)

☐ Private Health Insurance - Please complete Sections A and C

☐ Work cover/Third Party - Please complete Sections B and C

☐ Repat/Veterans Affairs - Please complete Entitlements and Section C

☐ Uninsured - Please complete Section C only

SECTION A: PRIVATE HEALTH INSURANCE

Fund Name: _____

Membership No: _____

Date Joined: / /

Type of cover: ☐ Single ☐ Family ☐ Other

Level of cover (if known): _____

Has this level of cover changed in the last 12 months?

☐ Yes ☐ No

Do you have an excess?

☐ Yes ☐ No Amount $ _____

Have you paid an excess this year?

☐ Yes ☐ No Amount $ _____

Date aware of present symptoms/condition: / /

SECTION B: WORKCOVER OR THIRD PARTY

☐ Work cover or ☐ Third Party (Please tick one box)

- The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company:

_____

Claim No: _____

Address: _____

Suburb: _____ State: _____

Postcode: _____

Telephone: _____

Date of Accident: / /

Please go to Section C - "Payment of Account"

SECTION C: PAYMENT OF ACCOUNT - ALL PATIENTS TO COMPLETE

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent

☐ Payment Information

Person responsible for payment of accounts - *Please provide your name, signature and today's date.*

Name: _____

Signature: _____

Date: / /

Patient's Signature: _____

Signature: _____

Date: / /

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

☐ Pre-admission Booklet

☐ Australian Charter of Healthcare Rights

☐ Your right to privacy under the Privacy Act

BINDING MARGIN - NO WRITING