BENDIGO HEALTH

UR No_____

Admission date _____

Consultant _____

Patient registration form

Please complete all details on BOTH SIDES

Have you been a patient at Bendigo Health before? Yes ☐ No ☐

Ms ☐ Miss ☐ Mrs ☐ Mr ☐ Other_____

Male ☐ Female ☐ Date of Birth_____

Surname: _____Given names: _____

Address: _____

Town: _____ State: _____Postcode:_____

Home Phone: _____ Work/Mobile: _____

Email address: _____

Same as postal address ☐ Previous Surname: _____

Postal Address: _____

Town: _____State:_____ Postcode: _____

Marital Status: _____

Religion: _____ Country of Birth: _____

Indigenous status: Aboriginal ☐ Aboriginal & Torres Strait Islander ☐

Torres Strait Islander ☐ Not Indigenous ☐

Interpreter required Yes ☐ No ☐ Preferred language: _____

Contact 1:

Full name _____Relationship:_____

Address: _____

Home phone: _____ Work/ Mobile: _____

Contact 2:

Full Name: _____ Relationship: _____

Address: _____

Home phone: _____ Work/Mobile: _____

Health Fund Details:

Name: _____Membership No: _____

Self-Pay: ☐

Medicare number: _____ Expiry date: _____

Reference Number: _____ (Number beside your name on card)

Pension card type_____ Pension card number_____

Expiry date: _____

Veterans Affairs number: _____ White ☐ Gold ☐

Local doctor details:

Full name: _____ Phone: _____

Name of Clinic / Practice: _____

Address: _____

Town: _____ Postcode: _____

Please return completed form to:

Patient Services, Bendigo Health, PO Box 126, Bendigo Vic 3552

Office use only: _____Updated by _____Date: _____