Care 24-7
@Calvary Lenah Valley
Emergency Department

Patient ID Label- Attach here

PATIENT REGISTRATION FORM

Have you visited the Calvary Lenah Valley Emergency Department before? Yes ☐ No ☐

PATIENT DETAILS:

Title:.....First Name: .....Last Name:.....

Gender: .....Pronouns.....

DOB..... County of Birth.....

Address.....

Suburb.....

PostCode.....State.....

Phone: (Mobile).....Phone: (Home- Including area code).....

E-mail .....

Indigenous Group: ☐ Aboriginal & Torres Strait Islander ☐ Aboriginal ☐ Torres Strait islander ☐ Non-Indigenous

Country of Birth.....

NEXT OF KIN DETAILS:

Title:.....First Name : .....Last Name:.....

Phone: (Mobile).....Phone: (Home- Including area code).....

Relationship.....

Alternative contact:

Title:.....First Name : .....Last Name:.....

Phone: (Mobile).....Phone: (Home- Including area code).....

Relationship.....

PERSON RESPONSIBLE FOR ACCOUNT:

☐ Patient ☐ Next of Kin

☐ Others (Please provide details below)

Title:.....First Name : .....Last Name:.....

Phone: (Mobile).....Phone: (Home- Including area code).....

Relationship.....

MEDICAL INSURANCE DETAILS:

Private Health Fund name.....

Membership Number.....

MEDICARE DETAILS:

Medicare Number..... Patient Reference No..... Expiry Date.....

DVA DETAILS:

DVA File No.....Type..... Expiry Date.....

PENSIONER DETAILS:

File No.....Type.....Issued Date.....

GP DETAILS:

General Practitioner Name:..... Practice Name.....

PRIVACY POLICY

The staff Care 24-7 operated Emergency Departments are committed to respecting your confidentiality and preserving your privacy as required by law. In this practice, it is customary for all doctors to have access to all of your medical records. If you have any concerns about other doctors at this practice being able to access your records, please discuss your concerns with your treating doctor. It is important that other people involved in your care, such as other doctors or health professionals i.e. allied Health, are informed of relevant parts of your medical history so they can best care for you. There are times when disclosure is necessary for the doctors in the practice to carry out a review of their practice for the purpose of improving the quality of care provided. This provides safeguards to protect the confidentiality of the information provided.

By signing, I acknowledge that I have understood and accept the Privacy Policy. I/We also agree that the personal details that I/We have provided in this form and otherwise are correct and true to my/our knowledge.

Signature	Print name	Date