Mater
Mothers' Private Hospital

Maternity Registration

Unit Record No._____
Surname_____
Given Names_____
DOB_____ Sex_____
AFFIX PATIENT IDENTIFICATION LABEL HERE

Due Date:____/____/_____

PATIENT DETAILS

Title: ☐ Mrs ☐ Miss ☐ Ms ☐ Other:_____ Surname:_____

Given Names:_____

Date of Birth:____/____/_____ Country of Birth:_____

Marital Status: ☐ Defacto ☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Other:_____

Language Spoken:_____ ☐ Needs Interpreter

Permanent / Residential Address:_____

Suburb:_____ State:_____ Postcode:_____

Phone Numbers: Home:_____ Mobile:_____ Work:_____

Email Address:_____

Indigenous Status: ☐ Australian South Sea Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Not Indigenous

Religion: (Optional)_____ Occupation:_____

Mailing Address:_____

Suburb:_____ State:_____ Postcode:_____

Temporary Address: (For Interstate / Overseas patients etc.)_____

Suburb:_____ State:_____ Postcode:_____

CONCESSION CARDS

Pension Card No.:_____ Expiry Date:____/____/____

Healthcare Card No.:_____ Expiry Date:____/____/____

DVA Card No.:_____ Card Colour:_____ Expiry Date:____/____/____

Safety Net Card No. (CN/SN):_____ Expiry Date:____/____/____

NEXT OF KIN

Title:_____ Surname:_____

Given Names:_____ Relationship:_____

Address:_____

Suburb:_____ State:_____ Postcode:_____

Phone Numbers: Home:_____ Mobile:_____ Work:_____

NEXT OF KIN

Title:_____ Surname:_____

Given Names:_____ Relationship:_____

Address:_____

Suburb:_____ State:_____ Postcode:_____

Phone Numbers: Home:_____ Mobile:_____ Work:_____

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Ver. 2.0
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PATIENT REGISTRATION 51

  Exceptional People. Exceptional Care.

Mater
Mothers' Private Hospital

Maternity Registration

Unit Record No._____
Surname_____
Given Names_____
DOB_____ Sex_____
AFFIX PATIENT IDENTIFICATION LABEL HERE

PRIVATE HEALTH INSURANCE DETAILS

Do you have Private Health Insurance? ☐ Yes ☐ No
Health Fund / Insurer:_____
Level of Cover / Plan Type / Table:_____ Policy Number:_____
☐ Single Cover ☐ Couple Cover ☐ Family Cover Have you held your current policy for over 12 months? ☐ Yes ☐ No
Do you have an excess / Co Payment? ☐ Yes ☐ No If yes, please specify the amount / Co Payment $_____

MEDICARE DETAILS

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Card Ref No.: ☐ Expiry Date:____/____/____
If no Medicare Card, please nominate person responsible for account:_____

GP / FAMILY DOCTOR DETAILS

Name:_____
Surgery Names:_____
Address:_____ Suburb:_____ Postcode:_____
Phone Number:_____ Fax Number:_____

OBSTETRICIAN

Name:_____
Surgery Names:_____
Address:_____ Suburb:_____ Postcode:_____
Phone Number:_____ Fax Number:_____

OTHER HEALTH CARE PROFESSIONAL

Name:_____
Surgery Names:_____
Address:_____ Suburb:_____ Postcode:_____
Phone Number:_____ Fax Number:_____

PREVIOUS HOSPITAL VISITS

Have you been hospitalised in the past 7 days? ☐ Yes ☐ No
Name of Hospital:_____
Date of Admission:____/____/____ Date of Discharge:____/____/____
Have you attended a Mater Health Services Hospital in Brisbane before? ☐ No ☐ Yes Date:____/____/____
Previous name if changed since last visit:_____

PATIENT ACKNOWLEDGMENT

I acknowledge full responsibility for accounts rendered by the Mater Health Services including any shortfall in reimbursement by my health fund. I agree to abide by terms and conditions of payment as outlined in the Schedule of Fees of the Hospital. I confirm the information supplied on this form is true in every respect.

Signed:_____ Date:____/____/____

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