

SOUTHSIDE ENDOSCOPY CENTRE

Using a **BLACK PEN**, please answer the following questions completely and accurately.

ADHERE PATIENT I.D LABEL HERE

DATE OF ADMISSION : ____ / ____ / 20 ____

PERSONAL INFORMATION

SALUTATION : Dr | Mr | Mrs | Miss | Ms (please circle)

DATE OF BIRTH : ____ / ____ / ____

SURNAME : _____ GIVEN NAMES: _____

RESIDENTIAL ADDRESS: _____

SUBURB : _____ POSTCODE : _____

Does your mailing address differ to above? : _____

PHONE NUMBERS : _____ (Home) _____ (Mobile)
_____ (Other) * Do you prefer appointment confirmation via SMS? Yes / No *

MEDICARE CARD

MEDICARE CARD NO: Expiry Date : ____ / ____ Ref No:

FINANCIAL DETAILS

PRIVATELY INSURED (HOSPITAL COVER)

Name of Fund : _____ Name of Policy (if known): _____

Membership Number : _____ Excess : \$ _____ Have you held Cover for 12+ months? YES / NO

PENSIONER HEALTH CARE CARD Number : _____ - _____ - _____ Expiry Date : ____ / ____

VETERANS AFFAIRS Gold Card White Card File Number : _____

REFERRING DOCTOR DETAILS

Referring Doctor : _____ Practice Suburb: _____

NEXT OF KIN

Next of Kin : _____ Relationship: _____

Address : _____ Emergency Contact No : _____

Who will be driving you home after your procedure? _____ Contact No: _____

STATISTICAL INFORMATION

The following questions are required by the Queensland Government for research purposes – (Your name will not be disclosed)
What is your?

- Occupation : _____ | Retired (if retired, please state occupation before retirement)
- Current Marital Status (please circle) : (Never Married | Married | Defacto | Widowed | Separated | Divorced)
- Country of Birth (For the UK or Africa please state country) : _____

Are you of : (Please tick a box)

- Australian Aboriginal origin
- Torres Strait Islander origin
- Australian Aboriginal and Torres Strait Islander origin
- Australian South Sea Islander ancestry
- None of the above

ADMISSION FORM