

## PATIENT PRE ADMISSION FORM

Date of Procedure: \_\_\_\_\_

Procedure/Item Number/s: \_\_\_\_\_

Doctor: \_\_\_\_\_

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mob Ph number: \_\_\_\_\_

Medicare Number:	Ref No:		Expiry:
Health Fund Details:	Fund Name:	No:	Excess?
Uninsured	Yes / No		
	Gender: Male / Female		
Date of Birth	Country of Birth:		
Marital Status:	Single / Married / De Facto / Widowed / Divorced		
Employment Status:	Employed / unemployed / retired / other		

### PERSON RESPONSIBLE / NEXT OF KIN DETAILS

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Name: \_\_\_\_\_

Relationship to Pt: \_\_\_\_\_

Address: \_\_\_\_\_

Mob Ph Number: \_\_\_\_\_

### The hospital fee/excess to be paid on or BEFORE admission either by:

- Direct Debit: BSB 064 214 Account No 1004 3340  
(Use your Surname as the Reference), please retain a copy of your payment and bring to your appointment
- EFTPOS/Visa/Mastercard - **WE DO NOT ACCEPT CASH**

**Patients need to contact their Health Fund prior to admission**

Completed forms need to be either emailed to: [pdpc.pgc@ramsayhealth.com.au](mailto:pdpc.pgc@ramsayhealth.com.au)  
or faxed to: 07 5588 9580 prior to admission