SMDCC
A PRIVATE
DAY ONLY HOSPITAL

SMDCC & PHARMACY – Admission Form 1 (AF1)

MR/MRS/MS/MISS Surname: _____First Name: _____

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: _____ Country of Birth: _____

Phone No: _____ Mobile: _____

Email: _____

Medicare No: _____ Card Reference (e.g., 1 or 2): _____ Expiry: _____

Pension No: _____ Expiry: _____

Health Care Card No: _____ Expiry: _____

Private Health Fund: _____ Number: _____

Veteran's Affairs No: _____ Type (Gold/Other): _____

Are you of Aboriginal and/ or Torres Strait Islander origin: ☐ Yes ☐ No

Interpreter Required: ☐ Yes ☐ No (If YES) Language: _____

Height: _____ Weight: _____

Occupation: _____ Religion: _____

Relationship Status (Please Circle): Married / Single / De Facto / Separated / Divorced / Widowed

Emergency Contact: _____ Relationship: _____

Phone No: _____ Mobile: _____

Family Doctor: _____

Safety Net Concession Card No: _____

Safety Net Entitlement No: _____

Upon reaching your Safety Net Limit, we can apply for a Safety Net Concession or Entitlement Card on your behalf. Would you like us to do that for you? ☐ Yes ☐ No

I have read the above information and agree to pay the patient co-payment of Pharmaceutical Benefits Scheme (PBS) medicines supplied to me. I give my consent for the collection and storage of information by the pharmacy for the purposes of providing my medications and accessing the PBS on my behalf.

Signed: _____ Date: _____