Note: you are implementing an online form so ensure your instructions are appropriate.

Patient Registration Form

Echuca Regional Health.
Admission Office.
P.O. Box 25, Echuca. Victoria. 3564.

BEFORE YOUR ADMISSION TO HOSPITAL
Please complete this form and post/deliver it to the Admission Office.

[redacted]

Personal Details (Patient)

Title: Mr.❑ Mrs.❑ Miss.❑ Ms.❑ Other:

Surname:

Given Name(s) in Full:

Previous Surname(s):

Date of Birth: / /

Sex: Male ❑ Female ❑

Country of Birth:

If Australia, what state:

Marital Status: Married ❑ Single ❑ Widowed ❑

Separated ❑ De Facto ❑ Divorced ❑

Do you wish to be visited by a Church Representative Yes ❑ No ❑

Religion:

Aboriginal / Torres Strait Islander: Yes ❑ No ❑

Address:

Postcode:

Phone No. (AH) (BH)

Next of Kin / Contact Person.

Name:

Address:

Phone No. (AH) (BH)

Relationship to Patient:

Medicare No:

Card I.D. No: Expiry Date:

[redacted]