

Admission Form

BOWEN HOSPITAL



WAKEFIELD HEALTH

Important!

Please post or fax this form as soon as possible before your admission together with the completed Health Questionnaire and Consent Form to:

Bowen Hospital
98 Churchill Drive
Crofton Downs
Wellington 6035
Fax (04) 479 8520

A stamped, addressed envelope is enclosed.

If this is not possible, please make sure you bring both forms with you when you arrive for admission.

Personal Details (patient to complete)

Admission Date:

Patient Name:

Mr/Ms/Mrs/Miss/Dr	<input type="text"/>	
	<small>Surname</small>	<small>Given names</small>
Preferred Name	<input type="text"/>	Date of birth <input type="text"/>
	<small>Known as</small>	Age <input type="text"/> NHI No <input type="text"/>
Previous Surname	<input type="text"/>	Ethnicity <input type="text"/>
	<small>If applicable</small>	
Address	<input type="text"/>	
	<input type="text"/>	
Telephone	<input type="text"/>	<input type="text"/>
	<small>Home</small>	<small>Work</small>
		<small>Mobile</small>
Email	<input type="text"/>	

Contact Person:

Mr/Ms/Mrs/Miss/Dr	<input type="text"/>	
	<small>Surname</small>	<small>Given names</small>
Relationship to patient	<input type="text"/>	
Address	<input type="text"/>	
	<input type="text"/>	
Telephone	<input type="text"/>	<input type="text"/>
	<small>Home</small>	<small>Work</small>
		<small>Mobile</small>
Next of kin if different from contact person	<input type="text"/>	
Mr/Ms/Mrs/Miss/Dr	<input type="text"/>	
	<small>Surname</small>	<small>Given names</small>
Telephone	<input type="text"/>	<input type="text"/>
	<small>Home</small>	<small>Work</small>
		<small>Mobile</small>

Family Doctor:

Name	<input type="text"/>
Clinic Address	<input type="text"/>

Payment (patient to complete)

Account to be charged to:

- Patient** Cheque / Eftpos / Credit Card (circle method of payment)
- Medical Insurance**

Name of Company

Policy type

Has the company given prior approval? Yes No

Approval number

ACC (Accident Compensation Corporation)

Paid under ACC Elective Contract

Paid under ACC Co. Payment

Claim number

Issuing office

Other

Cost (patient to complete, after telephoning the hospital for estimates)

I have been advised by the hospital that the hospital's costs are likely to be about \$ and that this figure does not include the cost of any significant complication(s) that may occur.

I understand that if I do not have medical insurance or the prior approval of my insurer I must settle my account in full at the time I am discharged.

I understand that specialists' and radiology fees will be billed separately.

Unpaid accounts will be forwarded to a collection agency and will incur associated costs.

Patient/Guardian

Signature

Date

Patient Information

Patient Rights

Bowen Hospital is committed to delivering your care within the code of the Health and Disability Services Consumers Rights. Please refer to your personal copy of the Code of Rights in your room.

Patient Satisfaction

If you have any concerns during your stay please ask to discuss these with the Nurse Manager or Director of Nursing. Any written communication should be addressed to our Director of Nursing.

Advocacy

Information regarding access to this service is also contained in the information booklet in your room.

Privacy

Please note that the information in your medical record is confidential and will not be released without your consent.