

M.R. No. _____

RANDWICK DAY SURGERY

Prov. No. 0999901X

This centre is owned and operated by Dr. G. Tier, Dr M. Stergoulis, Dr J. Cannon & Dr A. Theodore
2 Eurimbla Avenue
RANDWICK 2031

Tel. 9398 8190

Fax 9314 5331

PRE-ADMISSION FORM

Please answer ALL questions, printing clearly, and **RETURN THE FORM TO THE DAY SURGERY AT LEAST ONE WEEK PRIOR TO YOUR ADMISSION.** All information given is treated as strictly confidential.

Surname _____ Given Names _____

Home Address _____

_____ P/code _____

Postal Address (if different from above) _____ P/code _____

Telephone-Home _____ Business _____ Mobile _____

*Age _____ Date of Birth _____ Sex: M F Occupation: _____

Please be advised all patients over the age of 55yrs will require pre-anaesthetic testing, this includes Full Blood Count, BSL & ECG (speak to your dentist/RDS for further information)

Medicare No: _____ Valid to: _____ Ref: _____

Veterans Affairs No: _____ Pensioner Pharmaceutical Benefits No. _____

Do you have private health insurance - hospital cover? Yes No

Name of fund _____ Membership No. _____ Table _____

Name of member _____ Date joined _____ Date paid to _____

Family Single Date your cover was last updated (if applicable) _____

Next of Kin: Name _____ Tel. No. _____

Address _____

Relationship to patient : _____

Date of Admission: _____

Proposed treatment: _____ (check with your dentist if unsure)

Time of Admission: _____ am/pm

Name of admitting Dr/Dentist _____

Is this your first admission to Randwick Day Surgery? Yes No

Do you require an interpreter service ? Yes No

