Friendly Society Private Hospital

## PATIENT INFORMATION

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ Other

## BOOKING DETAILS

| | |
|---|---|
| Admission Date: | Admission Type: ☐ Same Day ☐ Inpatient |
| Admitting Doctor: | Regular GP/Clinic: |

## PATIENT IDENTIFICATION

| | |
|---|---|
| Title: Mr ☐ / Mrs ☐ / Miss ☐ / Ms ☐ | Family Name: |
| Given Names: | Previous Name/s: |
| Gender: ☐ Male ☐ Female ☐ Other | Date of Birth: |
| Residential Address: | |
| Postal Address (if different from above): | |
| Suburb: | Postcode: |
| Home Phone: | Work/Mobile: |
| Email: | Country of Birth: |
| Marital Status: ☐ Defacto ☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Widowed | Friendly Society Pharmacy: ☐ Yes ☐ No<br>Membership Number: |
| Religion: _____<br>Do you wish to receive Pastor's/Priest's/Clergy or church approved visitors?<br>☐ Yes ☐ No | Are you of Aboriginal or Torres Strait Islander descent:<br>☐ No<br>☐ Aboriginal<br>☐ Torres Strait Islander<br>☐ South Sea Islander |

## ENTITLEMENTS

☐ Medicare Card Number: _____ Expiry Date: ___ /___ /___

Reference Number (next to your name): _____

☐ **Private Health:**

Fund: _____ Membership Number: _____

Do you have an excess? ☐ Yes ☐ No Amount: $_____

Have you been with this fund longer than 12 months: ☐ Yes ☐ No

Have you confirmed with your health fund that you are covered for this procedure: ☐ Yes ☐ No

☐ **Work Cover:**

Claim Number: _____

Has approval been given by Work Cover QLD for private hospitalisation: ☐ Yes ☐ No

☐ **Self Insured:** Have you been given a fees estimate? ☐ Yes ☐ No

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT INFORMATION

MR 4

| | |
|---|---|
| ☐ Safety Net | Card Number: _____<br>Expiry Date: ____/____/____ |
| ☐ Pension | Card Number: _____<br>Expiry Date: ____/____/____ |
| ☐ Health Care Card | Card Number: _____<br>Expiry Date: ____/____/____ |
| ☐ Department of Veterans Affairs<br>Card Colour: ☐ Gold ☐ White | Card Number: _____<br>Expiry Date: ____/____/____ |

## EMERGENCY CONTACT DETAILS

| | |
|---|---|
| **First Contact Person:** | Relationship: |
| Address: | |
| Suburb: | Postcode: |
| Telephone (home): | Telephone (work/mobile): |
| **Second Contact Person** | Relationship |
| Address: | |
| Suburb: | Postcode: |
| Telephone (home): | Telephone (work/mobile): |
| **Third Contact Person (Optional):** | Relationship |
| Address: | |
| Suburb: | Postcode: |
| Telephone (home): | Telephone (work/mobile): |
| **Designated Driver (If Day Surgery Patient)** | **Telephone:** |

## MEDICAL DETAILS

| | |
|---|---|
| Have you been in hospital in the last 28 days?<br>☐ Yes ☐ No | Have you been in hospital in the last 7 days?<br>☐ Yes ☐ No |
| If yes, please name the hospital/s: | |
| Date/s of hospitalisation: | |

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