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 Membership Number:
Religion: _____ Do you wish to receive Pastor's/Priest's/Clergy or church approved visitors? ☐ Yes ☐ No	Are you of Aboriginal or Torres Strait Islander descent: ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ 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

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MR 4

☐ Safety Net	Card Number: _____ Expiry Date: ____/____/____
☐ Pension	Card Number: _____ Expiry Date: ____/____/____
☐ Health Care Card	Card Number: _____ Expiry Date: ____/____/____
☐ Department of Veterans Affairs Card Colour: ☐ Gold ☐ White	Card Number: _____ 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? ☐ Yes ☐ No	Have you been in hospital in the last 7 days? ☐ Yes ☐ No
If yes, please name the hospital/s:	
Date/s of hospitalisation:	

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