WOLPER
JEWISH HOSPITAL

8 Trelawney Street
Woollahra NSW 2025
Phone (02) 9328 6077
Fax (02) 9327 5973

PATIENT INFORMATION FORM

COMPUTER LABEL

Title	Family Name	M.R.N		
Given Names		A.M.O.		
Address	Street	Age	Sex	Ward
Suburb	Postcode	Admission Date		

☐ MEDICAL ☐ REHABILITATION ☐ PALLIATIVE CARE ☐ DAY REHABILITATION

PLEASE TICK APPROPRIATE BOX
Use black pen only and no fluorescent pens to be used

PERSONAL DETAILS

SURNAME

PREVIOUS NAMES

GIVEN NAMES

TITLE: ☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER

SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH AGE

STREET ADDRESS

POSTCODE

POSTAL ADDRESS
(IF DIFFERENT)

POSTCODE

TYPE OF USUAL ACCOMMODATION

☐ PRIVATE RESIDENCE (INCLUDING UNIT IN RETIREMENT VILLAGE)

☐ OTHER

PHONE HOME WORK

MOBILE

COUNTRY OF BIRTH

RELIGION

MARITAL STATUS: ☐ MARRIED OR DEFACTO ☐ SINGLE
☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

PREFERRED LANGUAGE SPOKEN AT HOME

EMPLOYMENT STATUS:

☐ EMPLOYED OCCUPATION

☐ RETIRED ☐ NOT EMPLOYED ☐ NOT KNOWN

ABORIGINAL: ☐ YES ☐ NO

TORRES STRAIT ISLANDER: ☐ YES ☐ NO

HOSPITAL INSURANCE: ☐ YES ☐ NO

NAME OF FUND

TABLE/SCALE

MEMBERSHIP NO.

IS THERE EXCESS ON YOUR TABLE: ☐ YES $ ☐ NO

MEDICARE DETAILS

If all Medicare details are not provided, all pharmacy will be charged at full rate, which cannot be amended.

CARD NUMBER

PATIENT REFERENCE NO. CARD EXPIRY DATE

BINDING MARGIN — DO NOT WRITE

PATIENT INFORMATION FORM WJH 008

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PATIENT INFORMATION FORM WJH 008

NEXT OF KIN

NAME

ADDRESS

PHONE HOME WORK

MOBILE

RELATIONSHIP

ADDITIONAL CONTACT PERSON

NAME

ADDRESS

PHONE HOME WORK

MOBILE

RELATIONSHIP

PENSION DETAILS

This information is required so the proper entitlements for free or concessional prescriptions can be made.

DO YOU HAVE — CARD NUMBER

☐ A PENSION CARD

☐ SAFETY NET ENTITLEMENTS

☐ REPATRIATION BENEFITS

CARD TYPE

OTHER DETAILS

DATE LAST ADMITTED TO HOSPITAL

HOSPITAL NAME

HAVE YOU BEEN ADMITTED TO THE WOLPER JEWISH HOSPITAL BEFORE?:

YES ☐ APPROX. YEAR NO ☐

GENERAL PRACTITIONER DETAILS

NAME

ADDRESS

PHONE FAX

EMAIL

WORKERS COMPENSATION/THIRD PARTY

IS YOUR ADMISSION NECESSARY BECAUSE OF AN ACCIDENT?

☐ YES ☐ NO IF YES, CAUSE OF INJURY

PLACE OF INJURY

A letter from your insurer accepting liability must be provided or full payment will be required on admission

CLAIM NUMBER

DATE OF ACCIDENT/INJURY

EMPLOYER NAME

EMPLOYER ADDRESS

PHONE FAX

EMAIL

INSURANCE COMPANY

ADDRESS

PHONE FAX

EMAIL

CONTACT PERSON

PAYMENT OF ACCOUNT

Wolper Jewish Hospital will forward accounts for hospitalisation on your behalf, asking that you only provide all insurance details prior to admission.

Any fees not covered by insurance are payable on admission, and any other fees raised during your admission are payable on discharge.

You may receive other services during your admission such as radiology. These will be billed separately by the service providers.

I understand and agree to pay all hospital accounts in the event that my health fund or insurance claim should be declined for whatever reason.

Person responsible for account to sign here please

X

OFFICE USE ONLY

☐ HEALTH FUND DETAILS CHECKED ☐ ESTIMATION DONE

☐ PATIENT ADVISED ☐ REHAB CERTIFICATE

BINDING MARGIN — DO NOT WRITE