Cure Day Clinics Fourways (Pty) Ltd • Reg no: 2015/173392/07
VAT no: 4510273834 • Practise no: 0770000644021
Sunset Square, 7 Sunset Lane, Lonehill, 2191
Private Bag x25, Elardus Park, 0047
Tel: 010 597 1973 • Fax: 086 230 0249
Email: admissions@cdc-fourways.co.za

PRE-ADMISSION FORM

Doctor's Information

Name of Dr: .... Practice No: ....

Diagnosis: .... ICD Code: ....

Procedure: ....

Date of Procedure: ....

Please FAX or E-MAIL 48 hours prior to admission

Please complete - Full details of patient

Surname: .... Full names: ....

Sex: Male ☐ Female ☐ Date of birth: ....

Preferred language: English ☐ Afrikaans ☐ Occupation: ....

ID No: .... Cell No: ....

Person responsible for account (Main member of Medical Aid)

Medical Fund: .... Option: ....

Title: Mr ☐ Mrs ☐ Ms ☐ Child ☐ Dr ☐ Prof ☐ Member No: ....

ID of Main member: .... Authorization No: ....

Main member's surname: .... Initials: ....

Postal address: .... Physical address: ....

....

....Code: .... Code: ....

Tel: (H) .... Cell: .... Email address: ....

Employer's Details (Main member/Person responsible for account)

Company name: .... Tel No: (W) ....

Postal address of employer: .... Occupation: ....

.... Postal Code: ....

Person to contact in case of an emergency / Next of kin

(Different address and tel)

Surname: .... Initials: .... Title: ....

Tel No: (W) .... Tel: (H) .... Cell: ....

Relationship to patient: ....

Main member / Person responsible for account

I, (Full names).. give Cure Day Clinics the authority to claim/submit account (s) on my behalf to ....(Medical Aid),

Member NO: ....

Date: ....

Signature