Cure Day Clinics Bellville (Pty)Ltd • Reg: 2012/018677/07 • PR NR: 077 000 0611379
De Tijger Business Park, 59 Hannes Louw Drive, Parow, 7499
Tel: (021) 000 5050 • Fax: 086 698 4237 • Email: admissions@cdc-bellville.co.za
PO Box x2067, Elarduspark, 0047

# 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 ☐ Dependant code: .....

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: ..... Email: .....

Tel: (H) ..... Cell: .....

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

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

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

..... Postal Code: .....

## Person to contact in case of 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 Bellville the authority to claim/submit the account (s) on my behalf to ..... (Medical Aid),

Member No: .....

Date: ..... .....

Signature

☐ *I hereby confirm all details supplied on this form are correct*

**SUBMIT**