VIDAMED

HOSPITAL | HOSPITAAL

PRE - ADMISSION FORM

DATE: ______________________

DOCTORS INFORMATION

NAME OF DR: ______________________ PRACTICE NR: ______________________

DIAGNOSIS: ______________________ ICD CODE: ______________________

CODE: ______________________ DATE OF PROCEDURE: ______________________

PLEASE FAX OR E-MAIL 48 HOURS PRIOR TO ADMISSION TO 044 690 3226

PLEASE COMPLETE FULL DETAILS OF PATIENT

SURNAME: ______________________ FULL NAMES: ______________________

SEX: MALE: ☐ FEMALE: ☐ DATE OF BIRTH: ______________________

LANGUAGE: ENG: ☐ AFR: ☐ DEPENDANT CODE: ______________________

ID NUMBER: ______________________ CELL NUMBER: ______________________

PERSON RESPONSIBLE FOR ACCOUNT (MAIN MEMBER OF MEDICAL AID)

MEDICAL FUND: ______________________ OPTION: ______________________

TITLE: MR ☐ MRS ☐ MISS ☐ DR ☐ PROF ☐ MEMBER NR: ______________________

ID OF MAIN MEMBER: ______________________ AUTHORIZATION NR: ______________________

MAIN MEM SURNAME: ______________________ INITIALS: ______________________

POSTAL ADDRESS: ______________________ PHYSICAL ADDRESS: ______________________

______________________ CODE: ________ ______________________ CODE: ________

TEL: (H): ______________ CELL: ______________ EMAIL: ______________________

EMPLOYER'S DETAIL (MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT)

COMPANY NAME: ______________________ OCCUPATION: ______________________

TEL (W) : ______________________ FAX (W) ______________________

POSTAL ADDRESS OF EMPLOYER: ______________________ CODE: ________

PERSON TO CONTACT IN CASE OF AN EMERGENCY / NEXT OF KIN (DIFFERENT ADDRESS AND TEL)

SURNAME: ______________________ INITIALS: ____________ TITLE: ______________________

TEL: (W): ______________ TEL: (H): ______________ CELL: ______________________

RELATIONSHIP TO PATIENT: ______________________ EMAIL: ______________________

MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT

I (FULL NAMES) : ______________________ GIVE VIDAMED DAY HOSPITAL THE AUTHORITY TO CLAIM/

SUBMIT THE ACCOUNT(S) ON MY BEHALF TO ______________________ (MEDICAL AID),

MEMBER NR: ______________________ SIGNATURE: ______________________

I HEREBY CONFIRM THAT ALL DETAILS ON THIS FORM ARE CORRECT: PRINT NAME: ______________________