



VIDAMED

PRE - ADMISSION FORM

HOSPITAL | HOSPITAAL

DATE: _____

DOCTORS INFORMATION

NAME OF DR: _____ PRACTICE NR: _____

DIAGNOSIS: _____ ICD CODE: _____

CODE: _____ DATE OF PROCEDURE: _____

PLEASE E-MAIL 48 HOURS PRIOR TO ADMISSION TO info@vidamed.co.za

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: _____

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

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

MEMBER NR: _____ SIGNATURE: _____

MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT

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

PRINT NAME: _____