Cure Day Clinics Erasmuskloof (Pty)Ltd • Reg: 2010/010594/07 • PR NR: 0448087
506 Jochemus Street, Erasmuskloof Ext 3, Pretoria 0153
Tel: 012 003 2001 • Fax: 086 230 0249
Email: admissions@cdc-erasmuskloof.co.za
Private Bag x25, Elarduspark, 0048

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 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 Clinic the authority

to claim/submin the account (s) on my behalf to ..... (Medical Aid),

Member No: .....

Date: ....

Signature