cure DAY HOSPITALS

WILGEHEUWEL

Cure Day Hospitals Wilgeheuwel (Pty) Ltd Reg Nr: 2015/173407/07
PR Nr: 0822671 • Vat Nr: 4250285568
Tel: (010) 072 0123 • Email: wilgeheuwel@cure.co.za
Wellness Crossing, Cascade Road, Wilgeheuwel, Gauteng
Web: www.cure.co.za

PRE-ADMISSION FORM

Please indicate your referring GP/Dentist's:

Name & Surname:..... Telephone No:.....

Address:.....

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 Hospitals the authority to claim/submit account (s) on my behalf to ..... (Medical Aid),

Member NO:.....

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

Signature

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