FORDSBURG CLINIC LIMITED
REG NO. 1986/002106/06 PR NO. 7700083
FORDSBURG CLINIC

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E-mail: reception@fordsburgclinic.co.za

PATIENT ADMISSION FORM

PATIENT DETAILS

1. SURNAME ..... FULL NAMES .....

2. RESIDENTIAL ADDRESS .....

.....

3. BUSINESS ADDRESS .....

.....

4. POSTAL ADDRESS .....

5. TEL (HOME) ..... TEL. (BUS) .....

CELL NO ..... E-MAIL .....

6. DATE OF BIRTH ..... AGE .....

7. OCCUPATION ..... LANGUAGE ..... GENDER .....

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

8. SURNAME ..... FULL NAMES .....

9. RESIDENTAL ADDRESS .....

.....

10. NAME AND ADDRESS OF EMPLOYER .....

.....

11. POSTAL ADDRESS .....

12. IDENTITY NUMBER .....

13. TEL (HOME) ..... (BUS) ..... (CELL) .....

MEDICAL AID DETAILS

14. NAME OF MEDICAL AID SCHEME .....

15. MEMBER'S NAME ..... MEDICAL AID NUMBER .....

16. EXTRA COVER (PLEASE SPECIFY) .....

....

SIGNATURE (PATIENT/MEMBER/PARENT) SIGNATURE (PERSON RESPONSIBLE FOR PAYMENT) DATE

I confirm that I have read the overleaf and undertake to abide therewith and be bound thereto.

FOR OFFICE USE

Admitting Doctor ..... *Referring Doctor* .....

Reason for Admission ..... *ICD Code* ..... *CPT Code* .....

Final Diagnosis .....

Authorisation Number ..... *Confirmation* ..... *Dep Code* .....