CINTOCARE

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patients@cintocare.com

PATIENT PERSONAL INFORMATION

Title		Initials		DOB		Identity number	
Surname							
First names							
Email address							

Mobile number	Work number	Home number
Residential address Code:	Postal address Code:	
Home language	Religion	Nationality

MEDICAL AID DETAILS

Medical aid name		Medical aid number	
Plan type		Dependant code	
Authorization number			

MAIN MEMBER'S DETAILS (ONLY IF THE MAIN MEMBER IS NOT THE PATIENT)

Title		Initials		DOB		Identity number	
Surname							
First names							

Mobile number	Work number	Home number
Home language	Email address:	
Residential address Code:	Postal address Code:	

EMPLOYMENT DETAILS OF THE ACCOUNT HOLDER/MAIN MEMBER

Employer		Occupation	
Employer address			
Contact person		Contact number	
Email address			

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Title		First name & surname	
Relationship			
Email address			

Mobile number	Work number	Home number

CLINICAL INFORMATION REGARDING THE PATIENT

ICD10 Code (Diagnosis)		CPT Code (Procedure)	
Notes			
Admitting doctor		Referring doctor	

Brief description of symptoms and complaints

PLEASE INDICATE IF YOU HAVE THE FOLLOWING CHRONIC CONDITIONS

☐ Hypertension ☐ Diabetes ☐ Cholesterol ☐ Cardiac ☐ Asthma ☐ Emphysema

☐ Epilepsy ☐ Anaemia ☐ Lupus ☐ Depression ☐ Multiple Sclerosis

☐ Other: _____

DECLARATION

I, _____

hereby confirm that all information supplied on this form is correct.

Signature: _____ Date: _____