Life HEALTH CARE **Faerie Glen Hospital**

Patient Registration / Pre-admission form

In case of a pre-admission please fax or hand in at pre-admissions ASAP - fax 012 361 1373 or 012 361 8991

Should you have any queries please contact reception for assistance on telephone 012 369 5600

HOSPITAL USE ONLY		
DOCTOR:	**SURGERY BOOKED TIME:** 00H:00M	**TIME OF ARRIVAL:** 00H:00M
WARD DETAILS:	**BED DETAILS:**	**PRE-ADMISSION NUMBER:**

PATIENT INFORMATION

PATIENT'S PERSONAL INFORMATION

IDENTIFIER TYPE: ID NUMBER /PASSPORT NUMBER /PATIENT LIFE NUMBER	IDENTIFIER NUMBER:	
SURNAME:	NAME:	INITIALS:
OTHER NAMES:	KNOWN AS:	
TITLE : DR /FR /MISS /MR /MRS /MS /PROF /REV	GENDER: MALE / FEMALE	DATE OF BIRTH : YYYY / MM / DD
MOBILE NUMBER: (000) 000 - 0000	WORK NUMBER: (000) 000 - 0000	HOME NUMBER: (000) 000 - 0000
PREFERRED METHOD OF CONTACT? MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N
EMAIL ADDRESS:		

RESIDENTIAL ADDRESS:		POSTAL ADDRESS:	
SUBURB:		SUBURB:	
CITY	CODE:	CITY	CODE:
MARITAL STATUS: SINGLE /MARRIED /DIVORCED	DIETARY PREFERENCE : FRUITARIAN / HALAAL / KOSHER / NONE / VEGAN / VEGETARIAN		
RELIGION:	CONGREGATION	MINISTER	

EMERGENCY CONTACT (PERSON TO BE CONTACTED IN CASE OF A MEDICAL EMERGENCY)

SURNAME:	NAME:	
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE		
MOBILE NUMBER: (000) 000 - 0000	EMERGENCY CONTACT'S ADDRESS:	
WORK NUMBER: (000) 000 - 0000		SUBURB:
HOME NUMBER: (000) 000 - 0000	CITY:	CODE:

ALTERNATIVE CONTACT: (PERSON NOT LIVING AT THE SAME ADDRESS)

SURNAME:	NAME:	
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE		
MOBILE NUMBER: (000) 000 - 0000	ALTERNATIVE'S CONTACT'S ADDRESS:	
WORK NUMBER: (000) 000 - 0000		SUBURB:
HOME NUMBER (000) 000 - 0000	CITY:	CODE:

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MEDICAL AID INFORMATION (PLEASE RECORD DETAILS AS PER MEDICAL AID CARD)

MEDICAL AID SCHEME:		PLAN:
MEMBER NUMBER:		AUTHORISATION NUMBER:
PRINCIPAL MEMBER SURNAME:		NAME
INITIALS:	TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV	SA ID NUMBER:
DATE OF BIRTH : YYYY / MM / DD	GENDER: MALE / FEMALE	DEPENDANT CODE:

HOSPITAL VISIT INFORMATION

ADMISSION DATE: YYYY / MM / DD	**SURGERY BOOKED DATE:** YYYY / MM / DD	**TIME:** 00H:00M
ADMITTING DOCTOR:	**REFERRING DOCTOR:**	
ALTERNATE DOCTOR:	**GENERAL GP:**	
ICD CODE / DIAGNOSIS:		
CPT CODE / PROCEDURE:		

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THIS ACCOUNT)

IDENTIFIER TYPE: ID / PASSPORT / PATIENT LIFE NUMBER/NOT ASSIGNED		IDENTIFIER NUMBER:	
SURNAME:	NAME:	INITIALS:	
OTHER NAMES:	KNOWN AS:		
TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV	GENDER: MALE / FEMALE	DATE OF BIRTH : YYYY / MM / DD	
MOBILE NUMBER: (000) 000 0000	WORK NUMBER: (000) 000 - 0000	HOME NUMBER: (000) 000 - 0000	
PREFERRED METHOD OF CONTACT: MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N	
EMAIL ADDRESS:			

RESIDENTIAL ADDRESS:		POSTAL ADDRESS:	
SUBURB:		SUBURB:	
CITY:	CODE:	CITY:	CODE:

CLINICAL INFORMATION

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE SYMPTOMS/COMPLAINTS PRESENT WHEN VISITING THE DOCTOR:

SHOULD YOU BE SUFFERING FROM DIABETES MELLITUS PLEASE INDICATE WHICH FORM OF CONTROL IS BEING PRACTICED?	TABLETS	INSULIN	DIET	NONE

DO YOU SUFFER FROM ANY OF THE FOLLOWING CHRONIC CONDITIONS/ILLNESS? (PLEASE INDICATE BELOW)

HYPERTENSION	MULTIPLE SCLEROSIS	CHOLESTEROL	EMPHYSEMA	ASTHMA	EPILEPSY	THYRIOD DISORDER	LUPUS
DEPRESSION	HEART FAILURE	PORPHYRIA	OTHER:				

PATIENTS PLEASE TAKE NOTE OF THE FOLLOWING:

1. **PRIVATE PATIENTS -** A prepayment is required on hospitalisation from patients not covered by medical aid. It is suggested that private patients contact the accounts department prior to admission to establish the estimated hospital cost.
2. **MEDICAL AID PATIENTS –** Please consult with your medical aid prior to admission obtaining pre-authorisation if necessary. Any short payments by your medical aid will be for your own account.
3. **MEDICAL AID CARD AND ID BOOK –** Must be produced on admission otherwise patient will be treated as private.
4. **PRIVATE/SEMI PRIVATE WARDS –** Medical aid patients requesting private wards will be expected to pay the private ward rate on admission. Please note private wards are subject to availability.

I _____ hereby declare that the information I have provided is true and correct and agree to the terms and conditions as set out above.

Patient Signature _____ **Date of Signature** _____

Sunnyprint Centurion (012) 664 0940