

PRE-ADMISSION BOOKING FORM



Pre-Auth No / Auth No: _____

In-hospital ☐ Partial Hospitalisation ☐

1 Details of Medical Aid Main Member:

Title: _____	Surname: _____	Full Names: _____
Initials: _____		DOB: _____
Postal address: _____		Med Aid Member Number: _____
_____	Postal Code: _____	Dependant Code: _____
Tel No (H) _____	(W) _____	I D Number: _____
Cell No: _____		Relation to patient: _____
Employer: _____		e-mail: _____
Occupation: _____		

2 Details of Patient:

First Name: _____	Surname: _____
Initials: _____	Title: _____
I D Number: _____	DOB: _____
Gender: M / F	Medical Aid: _____
Residential Address: _____	Plan: _____
_____	Member No: _____
_____	Dependant Code: _____
Postal Address: _____	Date of joining medical aid: _____
_____	Marital Status: _____
_____	e-mail: _____
Religion: _____	Cell no: _____
	Language: _____

3 Next of Kin not living with you:

Name and Surname: _____	Relationship: _____
Residential address: _____	Cell No: _____
_____	Tel No (H) _____ (W) _____
Postal Code: _____	

Who can we contact in an emergency: *(Different to Next of Kin)*

Name/Surname: _____	Relationship: _____
Tel No (H) _____ (W) _____	Cell No: _____

4 Psychiatric Treatment Information:

Referring Psychiatrist/Doctor's Name: _____	Tel No: _____
Diagnosis code: _____	Any chronic illnesses? _____
Admission Date: _____	

5 For in-office use to be signed on day of admission at Vista Clinic

I hereby declare that the information quoted above, is true and correct.

Patient Signature: _____	Date: _____
Main Member/Guardian Signature: _____	Date: _____