CINTOCARE

175 Frikkie de Beer Street
Menlyn Maine, Pretoria
0181
+27 12 945 3000
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)	
Date of operation			
Notes			
Admitting doctor	Dr HE Senske - pr no 0746398	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: _____