Johannesburg
EYE HOSPITAL

Johannesburg Eye Hospital
Tel: 011 782 1080 | Fax: 011 782 1090
Cnr Beyers Naude Drive & Waugh Ave, Northcliff
PO Box 1712, Northcliff 2115
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Patient Information (Please PRINT)

SURNAME ______ TITLE ______ INITIALS ______
FIRST NAMES ______
PATIENT I.D. ______
ACC. HOLDER I.D. ______
MEDICAL AID ______ E-MAIL ______
PLAN NAME ______ HOME TEL ______
MEDICAL AID NO. ______ CELL ______
PATIENT DEPENDANT CODE ______ WORK TEL ______
AUTHORISATION NO. ______ NEXT OF KIN ______
RESIDENTIAL ADDRESS ______ RELATIONSHIP ______
______ POSTAL CODE ______ TEL. NO. ______
POSTAL ADDRESS ______ FRIEND NAME ______
POSTAL CODE ______ TEL NO. ______
BUSINESS / WORK NAME ______ RELIGION ______
BUSINESS ADDRESS ______ DATE OF BIRTH ______
______ AGE ______
POSTAL CODE ______ GENDER / SEX ______

PATIENT PLEASE NOTE OUR REQUESTS:

- Be Present at the Clinic's Reception, ______ time. TAKE NOTE: Clinic opens at 07h00
- PLEASE BRING YOUR IDENTITY DOCUMENT, MEDICAL AID MEMBERSHIP CARDS AND AUTHORISATION NUMBER
- Patiets not on Medical Aid must settle account on admission
- Arrange for aresponsible person to fetch you from the Clinic
- Please complete this form in full. This will help with the administrative process and benefit both you and the Clinic.
- Please confirm procedure / admission with your Medical Aid
- Pleasenote that you are liable for he payment of the account should the Medical Aid not settle in full

Account Details / Main Member / Person Responsible for Account

SURNAME ______ TITLE ______ INITIALS ______
FIRST NAMES ______ HOME TEL ______
POSTAL ADDRESS ______ WORK TEL ______
POSTAL CODE ______ CELL ______
OCCUPATION ______ RELATIONSHIP TO PATIENT ______
BUSINESS NAME ______ MAIN MEMBER DATE OF BIRTH ______
BUSINESS ADDRESS ______ POSTAL CODE ______

Treatment Details

OPERATION ______ ICD 10 ______
SURGEON ______ ANAESTHETIST ______
I hereby declare that the above details are correct. SIGNATURE ______ DATE ______