

Pre-Admission Requirements

Title:		
First Names:		Surname: <input type="text"/>
ID/Passport:		
Procedure Date:		Dr: <input type="text"/>
Known Allergies:		

Residential Address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Postal Address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

Main Member Occupation:	<input type="text"/>
Business Name:	<input type="text"/>
Business Address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

Home Tel:	<input type="text"/>
Work Tel:	<input type="text"/>
Cell phone:	<input type="text"/>

Next of Kin:	<input type="text"/>
Relationship:	<input type="text"/>
Contact Number:	<input type="text"/>
Friend/Relative:	<input type="text"/>
Contact Number:	<input type="text"/>

MEDICAL AID DETAILS	
Medical Aid:	<input type="text"/>
Member no:	<input type="text"/>
Scheme option:	<input type="text"/>
Patient Dependant code:	<input type="text"/>
Authorization number:	<input type="text"/>

Person responsible for the Account (**Main Member of Medical Aid, Private patient account holder**)

Title:		
First Names:		Surname: <input type="text"/>
ID/Passport:		
Relationship:		
Email Address:		

When done please e-mail to: admissions@clubsurgical.co.za

On the day of your procedure please enter via the 18th street Boom Gate and park on UB (level -1) and enter via the elevator to the ground floor for admission

[Bring along ID and Medical AID Card](#)