Advanced MFT Day Hospital
209 Cape Road, Mill Park,
Port Elizabeth, 6001
amft@advancedhealth.co.za
www.advancedhealth.co.za

Pr. Nr.: BHF. 9990770001251937

ADMISSION / PRE-ADMISSION

PATIENT DETAILS

Title: | Initials:

First Name:

Surname: | Passport No:

ID Number: | Passport No:

Gender: Male | Female | Religion:

Language: | Nationality:

Occupation: | Allergy:

Residential Address: | Postal Address:

Postal Code: | Postal Code:

Home Number:

Work Number: | Email Address:

Cellphone Number: | Date to be Admitted:

EMPLOYER DETAILS (PERSON RESPONSIBLE FOR PAYMENT)

Employer Name: | Employer Tel:

Employer Address:

Postal Code:

PATIENT NEXT OF KIN

Next of Kin Name: | Home Number:

Next of Kin Address: | Work Number:

Cell Number:

Relationship:

Postal Code:

Next of Kin ID number:

ADDITIONAL CONTACT PERSON

Contact Name: | Telephone:

PATIENT MEDICAL AID DETAILS

Medical Aid: | Scheme Option:

Medical Aid Number: | Dependant Code:

GAP Cover: ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT

Member Surname:

Member Full Names: | Member Email:

Member Title: | Member Initials:

Home Tel: | Work Tel:

Cellphone no.: | Fax no.:

Residential Address: | Postal Address:

Postal Code: | Postal Code:

Employer Name: | Employer Tel:

Employer Address:

Postal Code:

Occupation:

Member ID Number.: | Beneficiary Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Referring Doctor.:

Attending Doctor: | Authorization No:

Diagnosis Code / IDC 10 Code: | Primary CPT Doctors Codes:

DETAILS OF ACCIDENT (IF APPLICABLE)

TYPE OF ACCIDENT:	MOTOR VEHICLE		MOTOR CYCLE		INJURED ON DUTY	
	DOMESTIC ACCIDENT		SPORT INJURY		OTHER	

Details of how the injury was sustained:

Patient / Guardian Signature: Date:

Main Member Signature: Date: