JHB EYE HOSPITAL

Cnr. Beyers Naudé Drive & Waugh Avenue
Northcliff Johannesburg
(011) 782 – 1080
admin@jhbeye.co.za
www.jhbeye.com

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

TEL. NO.

POSTAL CODE | FRIEND NAME

POSTAL ADDRESS | TEL NO.

POSTAL CODE | RELIGION

BUSINESS / WORK NAME | DATE OF BIRTH

BUSINESS ADDRESS | AGE

GENDER / SEX

POSTAL CODE

PATIENT PLEASE NOTE OUR REQUESTS:

- Be Present at the Hospital's Reception, _____ time. TAKE NOTE: Hospital 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.
- Please arrange for a responsible person to fetch you from the Hospital.
- Please complete this form in full. This will help with the administrative process and benefit both you and the Hospital.
- Please confirm your procedure/admission with your Medical Aid.
- Please note 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 NO

POSTAL ADDRESS | WORK NO

POSTAL CODE | CELL NO

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