# PRE-ADMISSION BOOKING FORM

VISTA CLINIC
teaching caring healing

**Pre-Auth No / Auth No:** _____

## 1 Details of Medical Aid Main Member:

Title: Mr | Surname: Motebejane | Full Names: Tshidi Comfort

Initials: TC | DOB: 16 November 1997

Postal address: Wonderpark estate, KarenPark | Med Aid Member Number: 909143910

Akasia | Postal Code: 0118 | Dependant Code: _____

Tel No (H ) 0696503904 | (W) _____ | Language: English

Cell No: _____ | I D Number: 9711165680086

Employer: HC Heat Exchangers | Relation to patient: Principal Member

Occupation: IS Analyst | e-mail: tshidi.motebs@gmail.com

## 2 Details of Patient:

Relationship to Main Member: Main | Surname: Motebejane

Initials: TC | Title: Mr | First Name: Tshidi

Residential Address: Wonderpark estate, KarenPark | Medical Aid: Discovery Flexicare

Postal Code: 0118 | Member No: 1

DOB: 16 November 1997 | Dependant Code: 909143910

I D Number: 9711165680086 | Inception Date: 2024-09-01

Gender: ✓ / F | Postal Address: Wonderpark Estate

Marital Status: Single | Akasia

e-mail: tshidi.motebs@gmail.com | Postal Code: 0118

Religion: Christian

Vehicle Details of patient, if applicable (Make, Model:) | Occupation: IS Analyst

_____ | Employer Tel No: 011 674 1237

Registration No: _____

## 3 Next of Kin not living with you:

Name and Surname: Sarah Motebejane | Relationship: Mother

Residential address: Mooikloof ridge | Cell No: 0847108277

Pretoria | Postal Code: 0081 | Tel No (H ) _____ | (W) _____

## Who can we contact in an emergency: *(Different to Next of Kin)*

Name/Surname: Levy Motebejane | Relationship Father

Tel No (H ) 0762789897 | (W) _____ | Cell No: 0762789897

**For transport (eg x-rays, scans, discharges etc):**

Name and Surname: _____ | Relationship _____

Tel No (H ) _____ | (W) _____ | Cell No: _____

**Note: If transport cannot be arranged, we have transport / taxi service available - **costs to be covered by the patient**

## 4 Psychiatric Treatment Information:

Referring Psychiatrist/Doctor's Name: _____ | Tel No: _____

Diagnosis code: _____ | Any chronic illnesses? _____

Admission Date: _____

## 5 I hereby declare that the information quoted above (main member and patient), is true and correct.

*To be signed on day of admission*

**Patient Signature:** _____ **Date:** _____

**Main Member/Guardian Signature:** _____ **Date:** _____