BAINES AVENUE CLINIC

66 Baines Avenue

ADVANCE BOOKING FORM

PAGE 2 MUST BE COMPLETED PRIOR TO PRESENTATION AT THE CLINIC BY THE PATIENT TO THE CLERK AT THE ADVANCE BOOKING DESK.
MONDAYS TO SATURDAYS ONLY
08-00 - 16-30 HOURS

1. **DETAILS: PATIENTS***(Please Print)*

Surname: _____ First Name _____

Residential Address: _____

Postal Address: _____ Telephone No: (H) _____ (B) _____

Date of Birth _____ Sex _____ Religion _____

Allergies: _____ I.D Number _____

2. **DETAILS: NEXT OF KIN***(Please Print)*

Surname: _____ First Name _____

Relationship: _____ Telephone No: HOME _____

WORK _____

Residential Address: _____

3. **DETAILS: PATIENT'S EMPLOYER***(Please Print)*

Company _____ Tel No _____

Physical Address _____

Postal Address _____

4. **DETAILS: PATIENT'S MEDICAL AID SOCIETY***(Please Print)*

Medical Aid Society _____ Number: _____ Suffix: _____

Member's Surname: _____ First Name: _____

Member's Occupation _____ Work Telephone No: _____

Member's Employer: _____

Member's Residential Address: _____

Member's relationship to Patient _____ Home Telephone No: _____

DEPOSIT REQUIRED: RECEIPT NO: _____ CASH/CHEQUE

$ _____ DATE:.....

DEPOSITS

1. Patients on Medical aid will be asked to lodge a deposit to cover any estimated shortfall.
2. Patients who do not satisfy the Clinic's requirements regarding Medical Aid Membership will be asked to lodge a deposit equivalent to the estimated fee. This includes ALL non residents and patients carrying foreign based Medical Aid Cards.
3. The Cashiers will accept Guaranteed cheques or cash payments only.
4. **REFUNDS ON DEPOSITS**
   - 4.1 Cash Patients — 15 days after date of discharge
   - 4.2 Medical Aid Patients — 15 days from date payment is received from Medical Aid Society
   - 4.3 All payments are by cheque Foreign based patients must make arrangements with a local resident for exchange payment
5. **CANCELLATION**
   Cancellation of an advance booking will incur an administration fee of 10%

ACCOMMODATION

The clinic cannot guarantee but will make every effort to provide a private rom if this is requested. Please note that an additional deposit is then required before admission

VALUABLES

The clinic will not be responsible for any losses, unless officially handed in for safekeeping

I have read understood and agree to the conditions given below.

SIGNED:.....(Patient/Next of Kin)

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INFORMATION TO BE COMPLETED BY MEDICAL PRACTITIONERS

MATERNITY PATIENTS

Para: _____ Gravida: _____ Blood Group _____

E.D.D.: _____

ALLERGIES: _____

MEDICAL HISTORY: _____

_____

OBSTERIC HISTORY: _____

_____

_____

DELIVERY PLAN: _____

_____

_____

GENERAL INFORMATION

Diagnosis: _____

Nature of operation: _____

Day Case/Minor in-Patient/Major In-Patient _____

Admission Date: _____

Operation Date: _____

Estimated stay: _____

Special Instructions: _____

_____

Family Practitioner: _____

Specialist Consultant: _____

Date: _____

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