CINTOCARE

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patients@cintocare.com

PATIENT PERSONAL INFORMATION

Title		**Initials**		**DOB**		**Identity number**	
Surname							
First names							
Email address							
Mobile number			**Work number**			**Home number**	
Residential address Code:			**Postal address** Code:				
Home language			**Religion**			**Nationality**	

MEDICAL AID DETAILS

Medical aid name		**Medical aid number**	
Plan type		**Dependant code**	
Authorization number			

MAIN MEMBER'S DETAILS (ONLY IF THE MAIN MEMBER IS NOT THE PATIENT)

Title		**Initials**		**DOB**		**Identity number**	
Surname							
First names							
Mobile number			**Work number**			**Home number**	
Home language			**Email address:**				
Residential address Code:			**Postal address** Code:				

EMPLOYMENT DETAILS OF THE ACCOUNT HOLDER/MAIN MEMBER

Employer		**Occupation**	
Employer address			
Contact person		**Contact number**	
Email address			

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Title		**First name & surname**	
Relationship			
Email address			

Mobile number	**Work number**	**Home number**

CLINICAL INFORMATION REGARDING THE PATIENT

ICD10 Code (Diagnosis)		**CPT Code (Procedure)**	
Notes			
Admitting doctor		**Referring doctor**	

Brief description of symptoms and complaints

PLEASE INDICATE IF YOU HAVE THE FOLLOWING CHRONIC CONDITIONS

☐ **Hypertension** ☐ **Diabetes** ☐ **Cholesterol** ☐ **Cardiac** ☐ **Asthma** ☐ Emphysema

☐ **Epilepsy** ☐ **Anaemia** ☐ **Lupus** ☐ **Depression** ☐ **Multiple Sclerosis**

☐ Other: _____

DECLARATION

I, _____

hereby confirm that all information supplied on this form is correct.

Signature: _____ Date: _____