CAMPUS HEALTH SERVICE
CONFIDENTIAL QUESTIONNAIRE

PATIENT INFORMATION:

Surname: ______________________ First Names: ____

Address (Stellenbosch) ____

I.D. No: ______________________________ Date of Birth: ________________________________

US No & 1st Year: ______________________ Student/Staff: ________________________________

Cell No: ________________________ Faculty/Department: ________________________________

Allergies: ____

Long term medication: ____

Have you been to CHS? ____________ Do you have siblings at US? (please give their names if so)

____

PERSON RESPONSIBLE FOR ACCOUNT / MAIN MEMBER OF MEDICAL AID:

Surname: ____________________________ Title (Prof/Dr/Rev/Mr/Mrs/Miss): _________________

Full names: ___________________________ I.D. No: ____________________________________

Tel (H): ______________________________ Tel (W): ____________________________________

Cell No: _____________________________ E-mail: ______________________________________

Additional e-mail address: ____

Postal address: ____

Home address: ____

MEDICAL AID DETAILS:

Name of Med. Fund: _________________________ Plan/Option: ___________________________

Number: __________________________________ Initials Main Member: _____________________

Main Member's Beneficiary Code: ______________ Your Beneficiary code: ___________________

Liability:

It is the policy of this office to submit all medical aid claims providing the proper information have been supplied by the patient. The patient is ultimately responsible for the account in full regardless of medical aid coverage.
I understand I am responsible for the amount in full. I confirm that the above information is true and correct. I undertake to inform you of any changes thereto within 14 days occurring.

SIGNATURE: ___________________________________ DATE: ____________________________

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

KAMPUSGESONDHEIDSDIENS
VERTROULIKE VRAELYS

PASIëNT BESONDERHEDE:

Van: ____________________ Volle name: ____________________

Adres (Stellenbosch) ____________________

I.D. Nr: ____________________ Geboortedatum: ____________________

US nr & 1e Jaar: ____________________ Student/Personeellid: ____________________

Sel Nr: ____________________ Fakulteit / Depart: ____________________

Allergië: ____________________

Langtermyn medikasie: ____________________

Is u al by KGD behandel? __________ Het u broers/susters by US? (verskaf hul name indien wel)

____

PERSOON VERANTWOORDELIK VIR REKENING/HOOFLID VAN MEDIESE FONDS:

Van: ____________________ Titel (Prof/Dr/Ds/Mnr/Mev/Mej): ____________________

Volle name: ____________________ I.D. Nr: ____________________

Tel (H): ____________________ Tel (W): ____________________

Sel Nr: ____________________ E-pos: ____________________

Addisionele e-pos: ____________________

Posadres: ____________________

Huisadres: ____________________

MEDIESE FONDS BESONDERHEDE:

Naam van Fonds: ____________________ Plan/Opsie: ____________________

Nommer: ____________________ Hooflid Voorletters: ____________________

Hooflid se afhanklike kode: ____________________ U Afhanklike kode: ____________________

Aanspreeklikheid

Dit is die beleid van hierdie kantoor om alle mediese fonds eise in te dien mits die regte inligting deur die pasient voltooi is. Die pasient bly verantwoordelik vir die volle rekening ongeag daarvan of die pasient mediese fonds dekking het.

Hiermee bevestig ek dat bogenoemde informasie korrek is. Ek onderneem om u binne 14 dae in kennis te stel van enige veranderinge.

HANDTEKENING: ____________________ DATUM: ____________________