



Stellenbosch
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**CAMPUS HEALTH SERVICE
CONFIDENTIAL QUESTIONNAIRE**

PATIENT DETAILS:

Surname: _____ First Names: _____

Address (Stellenbosch) _____

I.D. No: _____ Date of Birth: _____

US Nr: _____ Student/Staff: _____

Cell No: _____ Faculty/Department: _____

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: _____



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**KAMPUSGESONDHEIDSDIENS
VERTROULIKE VRAELYS**

PASIENT BESONDERHEDE:

Van: _____ Volle name: _____

Adres (Stellenbosch) _____

I.D. Nr: _____ Geboortedatum: _____

US nr: _____ Student/Personeellid: _____

Sel Nr: _____ Fakulteit / Depart: _____

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: _____