486-490 King Cetshwayo Highway Mayville 4058 | customercare@aakh.co.za | 031 492 3400

AAK Maternity Pre-Admission Form

Please email or hand in at Admissions Desk - **Email: admissions@aakh.co.za**
Should you have any queries please contact reception for assistance on: **031 492 3400**

PATIENT INFORMATION			
TITLE:	INITIALS:	SURNAME	
FIRST NAME/S:			
ID NUMBER:		DATE OF BIRTH:	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			
ALLERGIES:	RELIGION:	LANGUAGE:	
RESIDENTIAL ADDRESS:			
		POSTAL CODE:	
POSTAL ADDRESS:			
		POSTAL CODE:	
MEDICAL AID DETAILS			
MEDICAL AID NAME:		PLAN:	
MEMBER NUMBER:		DEPENDANT CODE OF PATIENT:	
PRINCIPAL MEMBER SURNAME:		NAME:	
PRINCIPAL MEMBER ID NUMBER:		DATE OF BIRTH:	
PRIVATE PAYING DETAILS			
PRIVATE FEES:			
HOSPITAL VISIT INFORMATION			
EXPECTED DELIVERY DATE:			
ADMITTING DOCTOR:			
ICD CODE / DIAGNOSIS:			
CPT CODE / PROCEDURE:			
MEDICAL AID AUTHORISATION NUMBER:			
CO-PAYMENT / DEDUCTIBLE:			

GUARANTOR INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
ID NUMBER:		DATE OF BIRTH:	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			

EMERGENCY CONTACT INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
RELATIONSHIP TO PATIENT:			
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			
RESIDENTIAL ADDRESS:			
		POSTAL CODE:	

ALTERNATE CONTACT INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
RELATIONSHIP TO PATIENT:			
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			

DOCUMENTS REQUIRED ON ADMISSION	
ORIGINAL MEDICAL AID CARD	
PATIENT ID	
MAIN MEMBER / GUARANTOR ID	

PLEASE TAKE NOTE OF THE FOLLOWING:

PRIVATE PATIENTS – THE MATERNITY CASH PACKAGE FEE IS REQUIRED ON DELIVERY.

MEDICAL AID PATIENTS - PLEASE SECURE AN AUTHORISATION NUMBER FROM YOUR MEDICAL AID PRIOR TO ADMISSION AS WELL AS CONFIRM ANY CO-PAYMENTS/DEDUCTIBLES.

ANY SHORT PAYMENTS BY YOUR MEDICAL AID WILL BE FOR YOUR OWN ACCOUNT.

PRIVATE WARD REQUESTS - AVAILABLE ON REQUEST
SUBJECT TO THE WARD AVAILABILITY AT THE TIME OF ADMISSION.

PRIVATE WARD RATE WITH DEPOSIT IS PAYABLE ON ADMISSION.

I HEREBY CONFIRM THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT AND AGREE TO THE TERMS AND CONDITIONS AS SET OUT ABOVE.

PATIENT SIGNATURE: _____ DATE: _____