BEST CARE AMBULANCE SERVICE PRODUCT

CALL FOR HELP! 082 9555 911

INFORMATION FORM

Please fax or e-mail application form through for processing.

Fax: (012) 379 5299 | Tel: (012) 379 5233 | E-mail: info@bestcareline.co.za | www.bestcareline.co.za

Please fill in this information form and send it through to us for processing. Please make sure that all the information that you supply in this information form is correct and that you update any information as time goes on.

PERSONAL INFORMATION:

Mr.		Mrs.		Miss.		Ms.		Dr.		Prof.		Child	

GENDER	Male		Female	

Full Name(s)														
Surname														
ID Number														
Date of Birth														

MEDICAL INFORMATION:

Do you have any allergies? If "Yes", please specify.	

Medical Illness. Tick "Yes" or "No"	MEDICAL CONDTION	YES	NO
	Heart disease / Previous heart attack?		
	Previous stroke?		
	Asthma / Respiratory disease?		
	High Blood Pressure?		
	Diabetes?		
	Epilepsy?		
	Dentures?		
	Pacer?		
	Thyroid Gland problem?		
	High levels of cholesterol?		
	Any other medical illness?		
	Previous Operations?		

Please specify Operations if "Yes":	

Please specify other medical illness if "Yes":	

General Practitioner	**Name**	
	Tel	
	Emergency	

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person 1	**Name**	
	Relation	
	Cell	

Emergency Contact Person 2	**Name**	
	Relation	
	Cell	

Emergency Contact Person 3	**Name**	
	Relation	
	Cell	

The three (3) selected "Emergency Contact Persons" will be called in the order that you as the client provided them to us. If we reached a relative, we will not contact the following relative.

Blood Group (If you know it)	
Are you an organ donor?	

Medical Aid	**Name**	
	Membership Number	
	Main Member	
	Medical Aid Option	

If you are not on a medical aid, would you like to utilize private emergency care at your own cost?

YES ☐
NO ☐

If you feel that we forgot important information, please attach it to your Information Form as an annexure. Due to mediation lists that can be very extensive, please attach a separate list of chronic medication use.

DO YOU HAVE OUR PERSONAL VEHICLE STICKER? IF YES, COMPLETE THE FOLLOWING TABLE:

VEHICLE REGISTRATION	VEHICLE COLOUR	MODEL	VIN NUMBER	INSURANCE	TRACKING COMPANY

I agree that Best Careline may capture and keep my personal and medical information on a secure database. I hereby give consent to Best Careline Identity to make use of my personal and medical information available to emergency staff and personnel on a "need to know" basis for the purpose of providing assistance during emergencies. I accept that Best Careline Identity cannot be held liable for any harm that this information might cause in the event of an emergency to me. I accept that the information supplied on **INFORMATION PAGE 1** and **INFORMATION PAGE 2** is truthful and correct according to my knowledge and that it is my own responsibility to keep the information updated. I have read the Terms & Conditions supplied on my application form and understand and accept it.

_____ _____

Signature of member/parent/guardian **Witness**

_____ _____

Date Signed **Place Signed**