REGISTRATION FORM / FICHE D'ENREGISTREMENT

PLEASE FILL-IN BLOCK LETTERS / VEUILLEZ REMPLIR EN LETTRE MAJUSCULES

Date:	/ /
Location:	☐ Darné ☐ Wellkin ☐ Grand-Baie ☐ Tamarin

(FOR OFFICE USE/POUR USAGE INTERNE)

UHID: _____

☐ First time

☐ Update patient record

Patient's surname/*Nom:*		MR ☐	MRS ☐	MISS ☐	MSTR ☐

(TO BE COMPLETED IF PATIENT IS A MINOR OR UNDER LEGAL ADMINISTRATION)

Patient's surname/*Nom:*		MR ☐	MRS ☐	MISS ☐	MSTR ☐

Name of parent or legally authorised representative:			
Address of parent or legally authorised representative:			
Phone number of parent or legally authorised representative:		Relationship with patient:	
Other names/ *Prénoms:*			
Date of birth/*Date de naissance:*			
Passport Number/ *Id Number* *Numéro De Passeport/ Carte D'identité*			
Residential Address/ *Adresse Résidentielle*			
Residential phone number *Téléphone du domicile*		Mobile phone number:	
Current address and telephone number in Mauritius: *Adresse et téléphone à L'ile Maurice*			
Nationality/ Nationalité		E-Mail Address *Adresse Électronique*	
Please confirm whether you are happy to receive offers and communications from C-Care by ticking:	☐ Email ☐ SMS ☐ WhatsApp		
Patient's occupation/ *Emploi du Patient*			
Patient referred from *Patient(e) Référé(e) Par*		(General Practitioner / Other Hospital) *(Médecin / Autres Hôpitaux)* ☐	
In case of emergency, please contact: *En cas d'urgence, veuillez contacter*			
Next of kin *Parent le plus proche*		Relationship: *Lien*	
Please advise for any special requests *Veuillez nous préciser votre requête* (e.g quiet room to pray/restricted visit, etc) *(exemple : un endroit pour prier, visite limitée, etc.)*			
Consultant 's Name/ *Nom du médecin traitant :*			
Name of person providing information/*Personne donnant l'information*			

Mode of payment / Mode de paiement: (Please check as applicable / Veuillez cocher la case appropriée)

Cash ☐ *Espèces*	Credit card ☐ *Carte de crédit*	Company's Insurance ☐ *Assurance de compagnie*	Self Insurance ☐ *Assurance Personnelle*	Corporate Company/ Société ☐

Name of Insurance (as applicable) *Nom de L'Assurance*	

PRIVACY STATEMENT AND CONSENT

C-Care wants you to know that we respect the privacy of your personal medical records and will do all we can to protect that privacy. We strive to always take reasonable precautions and security measures to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health information regarding treatment, payment or health care operations in order to provide health care that is in your best interests.

The information provided on this form is collected for the purpose of providing comprehensive health care to the patient. This information will be retained on the patient record and will be shared with the medical team at C-Care for purposes of administering and rendering medical care to the patient and/or with the patient's insurance carriers for billing purposes. The patient record may also be disclosed to a third party if necessary to protect the vital interests of the patient including to render emergency medical care or where required by law. The patient record will otherwise be kept confidential. For detailed information about how C-Care will be processing your personal data and your various rights, please read our Privacy Notice on C-Care website.

In signing this form, I certify as follows:

☐ The information provided above is accurate and I undertake to inform C-Care if there are any changes to the above.

☐ I have read and understood the above privacy statement. I understand that my personal data will be retained on C-Care's database and shall be shared with my treating doctor(s), medical team and other persons responsible for my medical care for purposes of treatment, payment, insurance billing and other health care operations.

☐ Where I have provided details of my insurance carrier for billing purposes, I hereby authorize C-Care to release such personal data related to my medical care as may be required to the nominated insurance provider. I hereby assign benefits to C-Care and understand and undertake that in the absence of accepted insurance cover, I/legal guardian shall be responsible for full payment to C-Care for services rendered.

Printed Name of Patient or Legally Authorised Representative:	
Signature of Patient or Legally Authorised Representative:	**Relationship with patient (if not completed by patient)**
Date:	

For Office Use

Registration completed by staff (name)		
Time taken for registration		
Copy of ID	YES ☐	NO ☐
If NO, follow up by		
Copy of ID Card received on	YES ☐	NO ☐
Surname exactly as per ID Card	YES ☐	NO ☐
Other names exactly as per ID card	YES ☐	NO ☐
Verify if address given on form	YES ☐	NO ☐
Information captured exactly as on HIS as per registration form	YES ☐	NO ☐
Signature of staff		