BEST CARE
"SERVICE FOR YOUR LIFE"
CARELINE IDENTITY
MY IDENTITY SAVED ME
BEST CARE AMBULANCE SERVICE PRODUCT

MEMBER UNIQUE CODE: _____

IN SUPPORT OF:
MERCY-CARE
EMERGENCY MEDICAL SERVICES

INFORMATION FORM

Please fax or e-mail Information Form through for processing

Marketing & Enquiries: 0823088259 | E-mail: info@bestcareline.co.za | www.bestcareline.co.za

Welcome the Best Careline Identification! Please complete this Information Form to the best of your ability and send it through to us for processing. Please make sure that all the information that you supply in this Information Form are correct.

PERSONAL INFORMATION OF THE MEMBER

Title Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Prof ☐ Other ☐ Gender Male ☐ Female ☐

Full Names	
Surname	
RSA Identity Number	
Date of Birth	

CONTACT INFORMATION OF THE MEMBER

Primary Contact No.		
Email Address		
Home Telephone		
Work Telephone		
Fax Number		
Home Address		CODE
Postal Address		CODE

MEDICAL INFORMATION (VERY IMPORTANT)

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

MEDICAL CONDITIONS	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? If "Yes" please specify:		
Previous Operations? If "Yes" please specify:		

GENERAL MEDICAL INFORMATION	
Do you have a General Practitioner? If "Yes" please identify	
Contact Number of General Practitioner (If Applicable)	
Are you an Organ Donor? If "Yes" please attach proof	
Do you know you your Blood Group? If "Yes" please specify	

MEDICAL AID INFORMATION	
Medical Aid Name	
Membership Number	
Medical Aid Option / Plan	
Main Member	

EMERGENCY CONTACT INFORMATION – WHO DO WE NOTIFY OF YOUR EMERGENCY?

EMERGENCY CONTACT PERSON 1	
Name & Surname	
Relationship	
Contact Number	

EMERGENCY CONTACT PERSON 2	
Name & Surname	
Relationship	
Contact Number	

EMERGENCY CONTACT PERSON 3	
Name & Surname	
Relationship	
Contact Number	

If you do belong to a medical aid, would you like to utilize private emergency care at your own cost?

YES ☐
NO ☐

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

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