RENAL CARE SOLUTIONS

Renal Care Solutions

Know Your Customer (KYC) Form

1. Customer Information

Full Name: _____

ID / Passport Number: _____

Date of Birth: _____

Nationality: _____

Residential Address: _____

Postal Code: _____

Email Address: _____

Mobile Number: _____

2. Medical Information (Optional)

Referring Doctor / Clinic: _____

Medical Aid Scheme: _____

Medical Aid Number: _____

Primary Diagnosis: _____

Current Treatment: _____

3. Employment & Financial Information

Employment Status: _____

Employer Name: _____

Employer Address: _____

Billing Responsible Party: _____

4. Next of Kin / Emergency Contact

Full Name: _____

Relationship: _____

Contact Number: _____

5. Verification Documents Checklist

- ☐ Proof of Identity
- ☐ Proof of Address
- ☐ Medical Aid Card
- ☐ Doctor’s Referral Letter

6. Data Privacy & Consent

I confirm that the information provided is accurate and complete.

Signature

Date