

Patient Information (as it appears on medical aid card)

Name:			Surname:		
Title:	Initials:		Sex:		Age:
Date of birth: (dd/mm/yyyy)			I.D. no:		
Relation to member:			Dependent code:		
Home Telephone no:			E-mail address:		
Physical Address:			Cellphone no:		
			Postal Address:		
	Code:			Code:	
Referring doctor:					

Person Responsible for Payment - Main Member (as it appears on medical aid card)

First Name + Surname:				Mr/Mrs:	
Date of Birth:		I.D. No:			
Relation to Member:			Dependent code:		
Employer:					
Work Telephone no:			Work Address:		
Fax no:				Code:	
Cell. no:			Medical Aid Plan Name:		
Medical Aid no:			Medical Aid:		

Do you suffer from Asthma?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Allergies:			Please specify:		

Female patients:	Are you pregnant?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
------------------	-------------------	-----	--------------------------	----	--------------------------

Contact details of Relative/Friend				
Name + Surname			Cellphone no:	
Physical Address:				Code:

Payment - Terms-strictly 30 days

Method of payment			
Medical Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Credit Card	<input type="checkbox"/>	Cash	<input type="checkbox"/>

Payment of the account in accordance with tariff of charges prevailing in the practice shall be the responsibility of the undersigned/patient.

In the event of the account not being timeously settled in full by the patient/undersigned and/or the relevant medical aid, then interest at a rate equal to 2% per month on the outstanding balance will be payable there on, until the date on which it is settled in full.

I undertake to be liable for all legal costs between attorney and client as well as tracing and collection fees due should it be necessary for legal action to be taken for the recovery of any amount owing arising out of treatment received by the above patient.

I consent to your being entitled to obtain credit and related information concerning myself at any time and/lodge, exchange and disclose such information with any credit bureau without any further notice to me.

I further consent to your being entitled to disclose any medical information regarding the above patient to my medical aid, as they require. I confirm that I am aware that the practice may make the X-ray and other digital images taken by the practice, available in a digital electronic form to medical practitioners,

Date: _____ Full name: _____ Signed: _____

For Office use only

Date:	Account no:	File no:
Examination:		
Pre-Authorised:	Capturedby:	