PATIENTS DETAILS

PLEASE PRINT CLEARLY

PATIENT'S **FULL FIRST NAME** ……**SURNAME**……..…….

ID NO:……..…… AGE:…… DATE OF BIRTH:……

ADDRESS (RES) …:…….

HOME TEL NO:……..…… WORK TEL NO……

OCCUPATION:…….. CELL NO. ……..

MARITAL STATUS:……

REFERRED BY :

NAME OF REFERRING DOCTOR ……..
GENERAL PRACTITIONER (IF DIFFERENT.)…….….

DETAILS OF MAIN MEMBER OF MEDICAL AID/ PERSON LIABLE FOR ACCOUNT

MEMBER: MR/MRS/MISS **FULL FIRST NAMES……..……**

SURNAME..…….…… RELATIONSHIP OF PATIENT TO MEMBER……....

IDENTITY NO: …….

POSTAL ADDRESS:…….…….

……CODE……..

PHONE: HOME: (CODE)…… WORK: (CODE)……..…….

CELL NO: …….

EMPLOYERS NAME & ADDRESS …….

E.MAIL ADDRESS (if any) ……..

NAME & TEL.NO. OF CLOSEST FRIEND/RELATIVE ……

MEDICAL AID DETAILS

FUND …….

PLAN …… MEDICAL AID NUMBER ……..…….

MEMBERS NAME ……DEPENDENT NO …….

GAP COVER – **YES OR NO**.....

DECLARATION

This is a Private Orthopaedic practice, and your fees are assessed according to the private tariff. **You will have to settle your account personally and submit receipt to your Medical Aid Society who will refund their share of the fee to you. Interest will be charged on all Overdue Accounts.**
Please discuss any queries with your Orthopaedic Surgeon.

SIGNATURE ……**DATE ……..**