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PERSONAL INFORMATION

Patient Names and Surname:

If minor, state name of parent or guardian:

Date of Birth: Gender:

Referring Doctor:

CHECK the box of any of the following which you have had:

Have you been in a hospital in the past two years?		Epilepsy		Diabetes	
Have you been under the care of a doctor during the past two years?		Tuberculosis		Hepatitis	
Any medicine or drugs during the past two years?		Heart Disease		Stroke	
Are you allergic to Penicillin / any other drugs or medicine?		Heart Murmur		Jaundice	
Have you had any excessive bleeding requiring special treatment?		Rheumatic Fever		Cough	
Have you had any other serious illnesses?		High Blood Pressure		Asthma	
If applicable: Are you pregnant?		Psychiatric Treatment		Arthritis	

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT / MAIN MEMBER:

Names and Surname:

Home Address / domicilium citandi et Executandi:

Postal Address:

ID Number: Home Tel:

Medical Aid: Cell:

Medical Aid Plan: Work Tel:

Medical Aid Number: Email:

OTHER TELEPHONE NUMBERS:

Wife / Mother: Relative / Friend:

Husband / Father:

AGREEMENT

I undertake to pay all costs as between attorney and client as well as collection commission of 10%. In the event of instituting any legal action emanating from this document / transection against me/us. I agree to pay any account received within 30 (thirty) days of statement date and acknowledge that I will pay the interest of 2% per month on any unpaid balance owing by me.

Name (person responsible for account): Date:

Signature (signed at practice): _____ *AGREE*

IMPORTANT NOTICE: PLEASE READ INFORMATION REGARDING TARRIFS. WE ARE NOT CONTRACTED TO ANY MEDICAL AID.