Dr. Sarel Botha
Maxillofacial & Oral Surgeon

MBChB (Pret), BChD (Pret), Dip Odont (Oral Surg) (Pret), MBA (Regent), MChD (Max.Fac.Med) (Pret), FCMFOS (SA), FIBCSOMFS, FIFHNOS

Practice No. 0557846

012 346 6032 | 012 346 7549 | 084 799 1111 | reception@sarelbotha.com | admin@sarelbotha.com | accounts@sarelbotha.com

Medical Suite 6, Cintocare Hospital Level 4, 175 Frikkie de Beer St, Menlyn Maine, Pretoria, 0181 | www.sarelbotha.com | Dr Sarel JP Botha

Personal Information

Patient Names and Surname: ....

If minor, state name of parent or guardian: ....Dep code: …………

ID Number: ………………………………………………

Date of birth: ……......... /…........... /…............   Gender: Male …… / Female ……

Referring doctor: ....

Have you been in a hospital in the past two years?	Yes / No
Have you been under the care of a doctor during the past two years?	Yes / No
Any medicine or drugs during the past two years?	Yes / No
Are you allergic to Penicillin / any other drugs or medicine?	Yes / No
Have you had any excessive bleeding requiring special treatment?	Yes / No

Circle the name of any of the following which you have had:

Heart Disease, Heart Murmur, High Blood Pressure, Rheumatic Fever, Asthma, Cough, Diabetes, Tuberculosis, Hepatitis, Jaundice, Arthritis, Stroke, Epilepsy, Psychiatric Treatment.

Have you had any other serious illnesses?	Yes / No
If Applicable: Are you pregnant?	Yes / No

Agreement

I, ...(name of person responsible for account) 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 / transaction 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 per month on any unpaid balance owing by me.

Note: Dr is not contracted to any medical aid

Person responsible for payment of account / main member:

Names and Surname: (Mr or Mrs or Miss) ....

ID Number: ....

Home Address: ....   Postal Address: ....

....

....

Home Tel: ....   Work Tel: ....

Cell: ....

Email: ....

Medical Aid: ....   Medical Aid Plan: ....

Medical Aid No: ....

Other Telephone Numbers:

Wife/Mother: ....   Husband/Father: ....

Relative/ Friend: ....

Signature: .... Date: ....