MAIN MEMBERS INFORMATION

ID NUMBER:* _____ SURNAME:* _____

FULL NAMES:* _____ INITIALS: _____ GENDER: MALE | FEMALE

TITLE: _____ DATE OF BIRTH:* _____ *CCYY-MM-DD*

HOME LANGUAGE: _____ HOME NUMBER: _____

CELL NUMBER:* _____ FAX NUMBER: _____

WORK NUMBER: _____ EMPLOYER: _____

EMAIL: _____

POSTAL ADDRESS:* _____

POSTAL CODE:* _____

PHYSICAL ADDRESS: _____

POSTAL CODE:* _____

MEDICAL AID SCHEME DETAILS

MEDICAL AID SCHEME:* _____ PLAN/OPTION:* _____

MEMBER NUMBER:* _____

GAP COVER: YES/NO M/M DEP CODE:* _____

PATIENT INFORMATION

ID NUMBER:* _____ SURNAME:* _____

FULL NAMES:* _____ NICK NAME: _____

TITLE: _____ INITIALS: _____

GENDER: MALE | FEMALE HOME LANGUAGE: _____

PATIENT DEP CODE:* _____ DATE OF BIRTH: _____ *CCYY-MM-DD*

CELL:* _____ WORK NUMBER: _____

Use the above cell number for appointments/test results YES/NO HOME NUMBER: _____

EMAIL: _____

OCCUPATION: _____ MARITAL STATUS: _____

RELATIONSHIP TO MAIN MEMBER:* _____

HEIGHT: _____ M **WEIGHT:** _____ KG **AGE:** _____ YEARS

REFERING DOCTOR: _____ TEL: _____

NEXT OF KIN

Not from the same physical address

FULL NAME: _____ SURNAME: _____

CELL: _____ INITIALS: _____ TITLE: _____

RELATIOSHIP: _____

Hereby I confirm that the information I supplied is true and I am responsible for any false information provided.

NAME IN PRINT:* _____

DATE OF SIGNATURE:* _____ SIGNATURE:* _____

Allow mass communication or notices from practice YES/NO

All fields marked with a * are mandatory. Please note that you (parent/guardian) remain liable for the account for services rendered by the practice, even if you are insured by a medical aid or other third party. Please ensure that you have read and signed the attached Doctor-Patient contract.