PATIENT DETAILS

Surname: .... First Names: .... Mr/Mrs/Miss: ....

Date of Birth: .... / .... / .... I. D. No.: ....

Occupation: .... Language: .... Marital Status: ....

Home Address: ....

.... Code: ....

Home Tel. No.: .... Cell No.: ....

E-Mail: ....

Postal Address: .... Code: ....

Employer's Name and Address: ....

Business Fax No: .... Business Tel. No.: ....

Nearest Family/Friend: Name: .... Relationship: ....

Address: .... Code: ....

E-Mail: .... Tel. No.: .... Cell No.: ....

Referring Doctor: ....

MEDICAL AID NAME: ....

MEDICAL AID NUMBER: ....

PLAN: .... DEPENDANT NUMBER: ....

METHOD OF PAYMENT: (Tick Box) | CASH | | CHEQUE | | CREDIT / DEBIT CARD | | DIRECT DEPOSIT / EFT |

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

Surname: .... First Names: .... Mr/Mrs/Miss: ....

Date of Birth: .... / .... / .... I. D. No.: ....

Occupation: .... Language: .... Marital Status: ....

Home Address: ....

.... Code: ....

Home Tel. No.: .... Cell No.: ....

E-Mail: ....

Postal Address: .... Code: ....

Employer's Name and Address: ....

Business Fax No: .... Business Tel. No.: ....

MEDICAL HISTORY

Allergies: ....

Rheumatic Fever: ....

Hypertension (High Blood Pressure): ....

Heart Trouble: ....

Stroke: ....

Bleeding Tendencies: ....

Diabetes: ....

Epilepsy: ....

Cortizone Therapy in past 2 years: ....

Porphyria: ....

Any other medical problems: ....

Any medication presently: ....

THE BILLING POLICY OF THIS PRACTICE DOES NOT FOLLOW THE DIFFERENT RATES AT WHICH THE VARIOUS MEDICAL SCHEMES REIMBURSE AT, OR ANY PRICE REFERENCE LIST.

PATIENTS' ARE RESPONSIBLE FOR FULL SETTLEMENT OF ACCOUNTS.

PLEASE READ THE FOLLOWING CONDITIONS CAREFULLY

I, the undersigned, do hereby acknowledge that:

1. I am aware of the prescribed rate of tariff charged by Dr O. J. van Heerden.

2. All accounts are payable on presentation and must be settled in full unless alternative payment arrangements have been made.

3. In the event of payment not being made in full, I shall be liable for, and agree to pay:

    a. Interest at a rate of 2% per month on the outstanding balance.

    b. All legal charges on attorney and own client scale. Such charges shall include any necessary tracing fees.

4. I understand that the account is always my responsibility until it is settled.

Please do not hesitate to discuss any matter with Dr van Heerden.

NAME: ....

SIGNATURE: ....

DATE: ....