MAIN MEMBER INFORMATION:

ID NUMBER: _____ *SURNAME: _____

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

HOME LANGUAGE: _____ TITLE: _____ *DATE OF BIRTH: _____

*CELL NUMBER: ( ) _____ HOME NUMBER: ( ) _____

WORK NUMBER: ( ) _____

FAX NUMBER: ( ) _____ EMPLOYER: _____

E-MAIL ADDRESS: _____ E-MAIL STATEMENTS? YES | NO

*POSTAL ADDRESS: _____

_____

*POSTAL CODE: _____

PHYSICAL ADDRESS: _____

_____

POSTAL CODE: _____

*MEDICAL SCHEME: _____ *PLAN/OPTION: _____

*MEMBER NO: _____ GAP cover Y | N * M/M DEP CODE: | |

PATIENT INFORMATION:

ID NUMBER: _____ *SURNAME: _____

*FULL NAMES: _____ INITIALS: _____ NICK NAME: _____

HOME LANGUAGE: _____ TITLE: _____ DATE OF BIRTH: _____

*CELL NUMBER: _____ Use this number for appointments/test results? YES | NO
Main member's Cell Phone numer will be used if this is NO

HOME NUMBER: ( ) _____ GENDER: MALE | FEMALE

WORK NUMBER: ( ) _____ E-MAIL ADDRESS: _____

OCCUPATION: _____ MARITAL STATUS: _____

*RELATIONSHIP TO MAIN MEMBER: _____ *PATIENT DEP CODE: | |

HEIGHT: _____ m WEIGHT: _____ kg AGE: _____ yrs

REFERRING DR: _____ TEL: ( ) _____

NEXT OF KIN: Not from the same physical address

FULL NAMES: _____ SURNAME: _____

CELL NUMBER: ( ) _____ INITIALS: _____ TITLE: _____

RELATIONSHIP TO PATIENT: _____

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 with * are mandatory. Please note that you (or your parent/guardian) remain liable for the account for services rendered by this 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.