MAIN MEMBER INFORMATION:

* ID NUMBER: * SURNAME:

* FULL NAMES:

INITIALS: GENDER: M F TITLE: * DATE OF BIRTH: C C Y Y M M D D

HOME LANGUAGE: EMPLOYER:

* CELL NUMBER: HOME NUMBER:

WORK NUMBER: FAX NUMBER:

E-MAIL ADDRESS: E-MAIL STATEMENT? Y N

* POSTAL ADDRESS:

* POSTAL CODE:

PHYSICAL ADDRESS:

POSTAL CODE:

* MEDICAL SCHEME:

* PLAN/OPTION: GAP COVER: Y N

* MEMBER NO.: MAIN MEMBER DEP CODE:

PATIENT INFORMATION:

* ID NUMBER: * SURNAME:

* FULL NAMES: NICK NAME:

INITIALS: GENDER: M F TITLE: * DATE OF BIRTH: C C Y Y M M D D

HOME LANGUAGE:

* CELL NUMBER: Use this number for appointments / test results Y N

*Main member's Cell Phone number will be used if the above is **No***

HOME NUMBER: WORK NUMBER:

E-MAIL ADDRESS:

OCCUPATION: MARITAL STATUS:

RELATIONSHIP TO MAIN MEMBER: * PATIENT DEPENDANT CODE:

AGE: years HEIGHT: , m WEIGHT: kg

REFERRING DR: TEL. NO.:

GP: TEL. NO.:

NEXT OF KIN: *(Not from the same physical address)*

INITIALS: TITLE: SURNAME:

FULL NAMES:

CELL NUMBER: 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: C C Y Y M M D D

* SIGNATURE: _____

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.