

MAIN MEMBER INFORMATION:

* ID NUMBER:		* SURNAME:	
* FULL NAMES:			
INITIALS:		GENDER:	M F
	TITLE:		* DATE OF BIRTH:
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:
* 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:	
* 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.