MAIN MEMBER INFORMATION:

ID NUMBER: _____ * SURNAME: _____

* FULL NAMES: _____ INITIALS: _____ GENDER: Male Female

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

* 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: O O

PATIENT INFORMATION:

ID NUMBER: _____ * SURNAME: _____

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

HOME LANGUAGE: _____ TITLE: _____ DATE OF BIRTH: CCYY-MM-DD

* CELL NUMBER: ( ) _____ Use this number for appointments/test results Yes No

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

HOME NUMBER: ( ) _____ GENDER: Male Female

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

OCCUPATION: _____ MARITAL STATUS: _____

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

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: CCYY-MM-DD * 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