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OFTALMOLOOG / OPHTHALMOLOGIST

All fields in this document are mandatory. Please note that all the information below is used in accordance with the Protection Of Personal Information (POPI) act, the National Health Act (NHA) and the National Credit Act (NCA) , in the best interrest of the patient and the practice. PLEASE NOTE: Refusal to provide this practice with any of the below information, or refusal to sign the appropriate documentation, can lead to refusal to be treated or attended to.

MAIN MEMBER INFORMATION:

* ID NUMBER:						* INITIALS:			
* SURNAME:						* FULL NAMES:			
* DATE OF BIRTH:	CCYY -	MM -	DD -						
* CELL NUMBER:					* E-MAIL ADDRESS:				
* HOME NUMBER:									
* WORK NUMBER:					* I WISH TO RECEIVE E-MAIL STATEMENTS:				YES / NO
* POSTAL ADDRESS:					POSTAL CODE:_____				
* PHYSICAL ADDRESS:					POSTAL CODE:_____				

MEDICAL SCHEME INFORMATION:

*MEDICAL SCHEME:	*PLAN/OPTION:			
* MEMBER NUMBER:	* GAP COVER:	YES	NO	

PATIENT INFORMATION:

* ID NUMBER:						* INITIALS:			
* SURNAME:						* FULL NAMES:			
* DATE OF BIRTH:	CCYY -	MM -	DD -						
* CELL NUMBER:					* E-MAIL ADDRESS:				
* HOME NUMBER:									
* WORK NUMBER:					* I WISH TO RECEIVE E-MAIL STATEMENTS:				YES / NO
* POSTAL ADDRESS:					POSTAL CODE:_____				
* PHYSICAL ADDRESS:					POSTAL CODE:_____				
* RELATIONSHIP TO MAIN MEMBER:					PATIENT DEPENDANT CODE:				

NEXT OF KIN:

* NAME:	I CONSENT THAT THE MENTIONED PERSON CAN BE CONTACTED WITH REGARDS TO THE FOLLOWING:	ACCOUNTS INFORMATION: ***(PLEASE INITIAL)***	YES/NO
* SURNAME:			
* TELEPHONE NUMBER:		EMERGENCY CLINICAL INFORMATION: ***(PLEASE INITIAL)***	YES/NO
* RELATION:			

I HEREBY CONFIRM THAT THE ABOVE INFORMATION I SUPPLIED IS TRUE AND THAT I AM RESPONSIBLE FOR ANY FALSE INFORMATION SUPPLIED

* NAME IN PRINT:	* SIGNATURE:
* DATE (CCYY-MM-DD):	