DR H PARKER INC
GENERAL PRACTITIONER

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PATIENT REGISTRATION FORM

PATIENT INFORMATION/ PASIENTINLIGTING

SURNAME/VAN: _____ EMAIL/EPOS: _____

FIRST NAME/NAME: _____ MOBILE/SEL: _____ ☐MALE ☐FEMALE

DATE OF BIRTH/ GEBOORTEDATUM: _____ ID NO/NR: _____

PERSON RESPONSIBLE FOR ACCOUNT/ MAIN MEMBER OF MEDICAL AID
PERSOON VERANTWOORDELIK VIR REKENING / HOOFLID VAN MEDIESE FONDS

TITLE/ TITEL: _____ SURNAME/ VAN: _____

FIRST NAME/NAME: _____ ID NO/NR: _____

DATE OF BIRTH/ GEBOORTEDATUM: _____ MOBILE: _____

HOME ADDRESS/ WOONADRES: _____

_____ POSTAL CODE: _____

TEL (H): _____ TEL(W): _____

EMAIL: _____

OCCUPATION/ BEROEP: _____ EMPLOYER/ WERKGEWER: _____

WORK ADDRESS/ BESIGHEIDADSRES: _____

NEXT OF KIN: _____ CONTACT NUMBER: _____

RELATIONSHIP: _____

NAME OF MEDICAL AID: _____ OPTION: _____

MEDICAL AID NUMBER: _____ DEPENDANT CODE: _____

The responsible person agrees to be responsible for the co-payment immediately after consultation and to settle any outstanding amount rejected by the medical scheme within 30 days after consultation. This person takes responsibility for obtaining the necessary authorisation from the medical aid where needed. I give consent to be contacted electronically by this practice.
Die bogenomede verantwoordelike persoon onderneem hiermee om enige bybetalings direk na konsultasie te betaal. Bogenoemde verantwoordelike persoon onderneem ook om binne 30 dae na konsultasie enige rekening te vereffen wat nié deur die mediese fonds betaal is nie. Indien daar enige magtigingsnommers benodig word is dit die bogenoemde persoon se verantwoordelikheid om dit te verkry. Ek gee die praklyk toestemming om my elektronies te kontak.

_____ _____

DATE: **SIGNATURE:**