

Dr Philip Botha

Specialist Physician/Infectious Disease Specialist

PATIENT DETAILS:

Surname:	Full Names:
Title:	ID No:
Employer:	Cell No:
Home Tel:	Work Tel:
Email address:	
REFERRING DR:	
GENERAL PRACTITIONER:	
CONTACT NUMBER GENERAL PRACTITIONER:	

PERSON RESPONSIBLE FOR THE ACCOUNT (MAIN MEMBER):

Surname:	Full Names:		
Title:	ID No:		
Street Address:	Postal Address:		
	Postal Code:		Postal Code:
Employer:	Occupation:		
Cell No:	Work Tel:		
Email address:			

MEDICAL AID DETAILS:

Fund:	Number:
Option:	Main Member ID No:
Dependant Code Main Member:	Dependant Code Patient:
Main Member:	

NEAREST FAMILY OR FRIEND/NEXT OF KIN – DIFFERENT TO THE ABOVE:

Name & Surname:	
Address:	
Contact Tel No:	Relationship to Patient:

I confirm that the above information, provided by me, is true and correct and the information may be used for contact in the future and for debt collection.

PLEASE NOTE: There is a **co-payment of R650.00** for all new patients seen in the consulting rooms, unless you belong to a contracted medical aid – please ask for further details. All follow-up consultations will be charged at contracted rates. Interest will be charged on outstanding amounts after 30 days.

It remains the patient's responsibility to settle all outstanding accounts in full.

Signature:	Date:
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