# Patient Registration Form

## PATIENT DETAILS:

Full Name & Surname: ______________________________________________________________________

Initials: _______________ Title: _____________ ☐Female ☐ Male DOB: _____ / _____ /______

Email Address: ___________________________________________________________________________

Home Tel: _________________________ Cell: __________________ Relationship to main member: _______________

## MEDICAL AID DETAILS:

Medical Aid Name: __________________________________________ Plan / Scheme: ____________________

Medical Aid Number: ________________________________________ Patient Dependent Code: _____________

## MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT / GUARANTOR:

Full Name & Surname: ______________________________________________________________________

Initials: _______________ Title: _____________ ☐Female ☐ Male DOB: _____ / _____ /______

Home Tel: _________________________ Cell: __________________ Email Address: ____________________________

Postal Address: ___________________________________________________________________________

Physical Address: _________________________________________________________________________

## EMPLOYER DETAILS:

Company Name: ___________________________________________ Tel Number: _____________________________

Contact Person Name: ______________________________________ Town: _____________________________________

## RELATIVE /FRIEND:

Full Name & Surname: ______________________________________________________________________

Tel Number: ___________________________________ Relationship to main member: ____________________________

**YOUR REFERRING DOCTOR NAME:** ____________________________________________________________

I confirm that the information supplied is true. I agree that it is the responsibility of the member to obtain pre-authorization should his/her scheme require so. The member will carry the costs / penalties incurred as a result of failed pre-authorization. I further understand that the member is personally responsible for settlement of the account and if applicable, for the submission thereof to the medical aid. Should legal steps be instituted for collection of this, I shall be liable for costs incurred. I hereby give consent that the ICD10 codes of my examination be disclosed to my medical aid in order to qualify for funding. After hour fees might apply that are not covered by Medical Aid. All procedures performed at this facility will be online and available to a restricted community of physicians.

**Name (Print):** __________________________ **Signature:** _______________________ **Date:** ____________________