

**MAIN MEMBER INFORMATION:**

|                   |                      |                       |                                                                                                                                                                                         |
|-------------------|----------------------|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| * ID NUMBER:      | <input type="text"/> | * SURNAME:            | <input type="text"/>                                                                                                                                                                    |
| * FULL NAMES:     | <input type="text"/> |                       |                                                                                                                                                                                         |
| INITIALS:         | <input type="text"/> | GENDER:               | <input type="text"/> M <input type="text"/> F                                                                                                                                           |
| HOME LANGUAGE:    | <input type="text"/> | TITLE:                | <input type="text"/>                                                                                                                                                                    |
| * CELL NUMBER:    | <input type="text"/> | * DATE OF BIRTH:      | <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D |
| WORK NUMBER:      | <input type="text"/> | EMPLOYER:             | <input type="text"/>                                                                                                                                                                    |
| E-MAIL ADDRESS:   | <input type="text"/> | HOME NUMBER:          | <input type="text"/>                                                                                                                                                                    |
| * POSTAL ADDRESS: | <input type="text"/> | FAX NUMBER:           | <input type="text"/>                                                                                                                                                                    |
| PHYSICAL ADDRESS: | <input type="text"/> | E-MAIL STATEMENT?     | <input type="text"/> Y <input type="text"/> N                                                                                                                                           |
|                   | <input type="text"/> | * POSTAL CODE:        | <input type="text"/>                                                                                                                                                                    |
|                   | <input type="text"/> |                       |                                                                                                                                                                                         |
|                   | <input type="text"/> | POSTAL CODE:          | <input type="text"/>                                                                                                                                                                    |
| * MEDICAL SCHEME: | <input type="text"/> |                       |                                                                                                                                                                                         |
| * PLAN/OPTION:    | <input type="text"/> | GAP COVER:            | <input type="text"/> Y <input type="text"/> N                                                                                                                                           |
| * MEMBER NO.:     | <input type="text"/> | MAIN MEMBER DEP CODE: | <input type="text"/>                                                                                                                                                                    |

**PATIENT INFORMATION:**

|                              |                            |                                                                        |                                                                                                                                                                                         |
|------------------------------|----------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| * ID NUMBER:                 | <input type="text"/>       | * SURNAME:                                                             | <input type="text"/>                                                                                                                                                                    |
| * FULL NAMES:                | <input type="text"/>       | NICK NAME:                                                             | <input type="text"/>                                                                                                                                                                    |
| INITIALS:                    | <input type="text"/>       | GENDER:                                                                | <input type="text"/> M <input type="text"/> F                                                                                                                                           |
| HOME LANGUAGE:               | <input type="text"/>       | TITLE:                                                                 | <input type="text"/>                                                                                                                                                                    |
| * CELL NUMBER:               | <input type="text"/>       | * DATE OF BIRTH:                                                       | <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D |
| HOME NUMBER:                 | <input type="text"/>       | Use this number for appointments / test results                        | <input type="text"/> Y <input type="text"/> N                                                                                                                                           |
| E-MAIL ADDRESS:              | <input type="text"/>       | Main member's Cell Phone number will be used if the above is <b>No</b> |                                                                                                                                                                                         |
| OCCUPATION:                  | <input type="text"/>       | WORK NUMBER:                                                           | <input type="text"/>                                                                                                                                                                    |
| RELATIONSHIP TO MAIN MEMBER: | <input type="text"/>       | MARITAL STATUS:                                                        | <input type="text"/>                                                                                                                                                                    |
| AGE:                         | <input type="text"/> years | * PATIENT DEPENDANT CODE:                                              | <input type="text"/>                                                                                                                                                                    |
| REFERRING DR:                | <input type="text"/>       | TEL. NO.:                                                              | <input type="text"/>                                                                                                                                                                    |
| GP:                          | <input type="text"/>       | TEL. NO.:                                                              | <input type="text"/>                                                                                                                                                                    |

**NEXT OF KIN:** (Not from the same physical address)

|              |                      |                          |                      |          |                      |
|--------------|----------------------|--------------------------|----------------------|----------|----------------------|
| INITIALS:    | <input type="text"/> | TITLE:                   | <input type="text"/> | SURNAME: | <input type="text"/> |
| FULL NAMES:  | <input type="text"/> |                          |                      |          |                      |
| CELL NUMBER: | <input type="text"/> | RELATIONSHIP TO PATIENT: | <input type="text"/> |          |                      |

**Hereby I confirm that the information I supplied is true and I am responsible for any false information provided**

|                                                   |                                                                                                                                                                                         |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| * NAME IN PRINT:                                  | <input type="text"/>                                                                                                                                                                    |
| * DATE OF SIGNATURE:                              | <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D |
| * SIGNATURE:                                      | <input type="text"/>                                                                                                                                                                    |
| Allow mass communication or notices from practice | <input type="text"/> Y <input type="text"/> N                                                                                                                                           |

**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.**