PATIENT DETAILS FORM — DR I.M. SALEJEE — web1

[1]. PATIENT DETAILS name/date of birth **as per medical aid card** only **FILE NO:**

SURNAME: Dependant no ID:-

FULL NAME: TITLE: DATE OF BIRTH:

PHONE (CELL): (W): (H):

EMAIL: FAX

POSTAL ADDRESS:

[2.] PERSON RESPONSIBLE FOR ACCOUNT

SURNAME: I.D.NO:

FULL NAME: DATE OF BIRTH: / /

PHONE (CELL): (W) (H):

EMAIL: FAX

POSTAL ADDRESS: EMPLOYER:

[3.] MEDICAL AID names / date of birth to be **AS PER MEDICAL AID CARD ONLY**

NUMBER **M.A. NAME** **OPTION** .

DEPENDANT	NAMES	DT OF BIRTH	DEPENDANT	NAMES	DT OF BIRTH
(00)		/ /	(04)		/ /
(01)		/ /	(05)		/ /
(02)		/ /	(06)		/ /
(03)		/ /	(07)		/ /

[4]NON-MEDICAL AID payment due per visit	CASH:	CHEQUE :	CREDIT CARD:	EFT PRE TREATMENT PAYMENT	
[5]ASOURCE OF REFERRAL	ADVERT	SIGN INSIDE	OUTSIDE	FRIEND	NAME

[6]COSTS The cost for the initial visit i.e. consultation can vary from R350for a specific consultation to R850 for a full consultation. Patients are responsible to check that medical aid benefits are available for treatment costs. Certain specialized procedures are charged at above scale of benefit rates per quotations provided

[**7**]. PATIENT LIABILITY (1.) Patients are responsible to ensure benefits are available and that full payment is received for all services rendered. (2.)In the event of medical aid non-payment of fees within 30days from date of treatment, the patient is liable (3) In the event of failure to make payment, the patient will be liable for all legal costs plus interest (4)Appointments not kept or rescheduled under 24 hours will be charged a R700/hour LATE CANCELLATION FEE

☐ **[8**.] PATIENT DECLARATION: I hereby confirm I have read and accept the terms of treatment outlined above.

PATIENT NAME: **SIGN:** **DATE:**

*** O F F I C E U S E O N L Y ***

1.V1 FORM CHECK V1 EXACT UPDATE **dt** **name**

2.V2+ PT DETAILS STATUS CHECK

Date ____ Staff	Date ____ Staff	Date ____ Staff	Date ____ Staff
Date ____ Staff	Date ____ Staff	Date ____ Staff	Date ____ Staff
Date ____ Staff	Date ____ Staff	Date ____ Staff	Date ____ Staff
Date ____ Staff	Date ____ Staff	Date ____ Staff	Date ____ Staff

3.a/c update - GUARANTOR ACCOUNT NUMBER : 4.MA INFO FILE option info on file YES NO

5MA BENEFITS	Dt1/staff		Dt2/st	Dt 4/st	Dt4/st	
1. Treatment to be done						
2. BASIC/SPEC available						
3. famly/indiv/savg/auth						
4. / MA- STAFF/TIME						
5. staff / date						