DR OSCAR CHRISTOPHER SHIMANGE

PATIENT PERSONAL DETAILS **FOLDER NO.....**

SURNAME:	MARITAL STATUS:
FULL NAMES:	
I.D.NUMBER:	DATE OF BIRTH: / /19
DEPENDANT CODE OR NUMBER:	STUDENT NO IF STUDENT:
OCCUPATION:	HOME LANGUAGE:
POSTAL ADDRESS:	RESIDENTIAL ADDRESS:
	EMPLOYERS NAME
PATIENT CONTACT NUMBERS	
TEL (W)	EMPLOYERS ADDRESS
TEL(H	
CELL NO:	
FAX NO	
FAX TO MAIL	
E-Mail Address:(Home)	(Work)
SPOUSE DETAILS/PARENT DETAILS OR(PERSON RESPONSIBLE FOR THE ACCOUNT)	
NAME OF THE SPOUSE/PARENT:	
IDENTITY NUMBER OF SPOUSE/PARENT:	
SPOUSE/PARENT EMPLOYER:	OCCUPATION:
TELEPHONE NUMBER:	CELL NO:
FAX NO	FAX TO MAIL
Email @ Home:	Email @ Work:
ADDRESS OF SPOUSE/PARENT EMPLOYER:	

PATIENT'SMEDICAL AID DETAILS/PRIVATE MEMBER NAME:				
MEDICAL AID:	PLAN TYPE:			
MEMBER MED AID NUMBER:				
DOES YOUR PLAN TYPE COVERS PRIVATE GYNAECOLOGY AND PRIVATE HOSPITALS	YES		NO	
Some Medical Aids do not pay for private gynaecology and private hospitals services, but only pay gynaecology at state hospital .It is your duty to ensure that your medical society covers or you will be declared private patient.				
PATIENTS MOTHER/RELATIVE/FRIEND & Address N:B (Person who does not live at same address				
1.Name:	2.Name:			
Address:	Address:			
Relationship:	Relationship:			
TEL WORK ( )	TEL WORK ( )			
TEL.HOME( )	TEL .HOME( )			
CELL :	CELL :			
Email:	Email:			
REFERRING/FAMILY DOCTOR'S NAME:				

I,---------- I.D NO----------(Name & I.D NO of the person responsible for payment of account) Declare that the above particulars are true and correct. I undertake to settle the account within 30 days of the date of the appointment and undertake to pay for Any appointments not cancelled .I agree to the charging of the maximum compounds interest rate prescribed by the legislation to any outstanding amount .Should it be necessary to institute action to recover any amount owing ,I agree to pay all charges and cost incurred –not restricted to party and party scale. undertake to inform the practice of my change of address. I n the event of any payment being received by myself from my medical aid in Lieu of services performed by Dr. Shimange to myself , I undertake to immediate pay over such amount to Dr. Shimange.

INFORMATION TO ALL PATIENTS

NOTE: Please note this practice is not contractually bound to any medical aid. We determines our rates according to accepted legal frame work . Feel free to discuss with us about charges.
The patient is responsible for any amount which your medical aid does not pay.

Signed at :Room 511 Medforum Medi-Clinic ,Pretoria on the ...../.....20

Signature:.----------Witness:.----------checked by.....