DR ANDY ZAIDMAN MB BCh (Wits)

Practice No 1571354

PATIENT INFORMATION FORM ***ACCOUNT NO: ________________***

MAIN MEDICAL AID MEMBER'S DETAILS

TITLE: __________ FIRST NAMES: ____

INITIALS: ______________ SURNAME: ____

DATE OF BIRTH: _____________________________ ID NO: ________________________________

POSTAL ADDRESS: ____

____ POSTAL CODE: _______________________

RESIDENTIAL ADDRESS: ____

____ POSTAL CODE: _______________________

WORK TEL NO: _________________________ HOME TEL NO: ______________________________

CELL NO: _____________________________ EMAIL ADDRESS: _____________________________

EMPLOYER:___________________________WORK ADDRESS: _______________________________

DEPENDANT'S DETAILS *NAME* *SEX* *IDENTITY NUMBER*

1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL AID DETAILS *MEDICAL AID NAME: ________________________________*

PLAN OPTION: __________________________ MEDICAL AID NO: __________________________

PERSONAL REFERENCE: (NOT A FAMILY MEMBER LIVING WITH YOU)

FULL NAME: _________________________________ TEL NO: ______________________________

KINDLY SETTLE YOUR ACCOUNT AT THE TIME OF YOUR CONSULTATION - THANK YOU!

I, THE UNDERSIGNED, DO HEREBY AGREE THAT:

1. *PAYMENT OF THE ACCOUNT IN ACCORDANCE WITH THE TARIFF OF CHARGES PREVAILING IN THIS PRACTICE SHALL BE THE RESPONSIBILITY OF MYSELF, THE UNDERSIGNED.*
2. *IN THE EVENT OF MY ACCOUNT NOT BEING TIMEOUSLY SETTLED IN FULL BY MYSELF, THEN INTEREST AT A RATE EQUAL TO 2.5% PER MONTH ON OUTSTANDING BALANCES WILL BE CHARGED AND IS PAYABLE BY MYSELF.*
3. *I HEREBY DECLARE THAT I AM THE LEGAL GUARDIAN/CUSTODIAN OF THE ABOVE CHILD AND UNDERSTAND & ACCEPT THE TERMS OF PAYMENT.*
4. *I UNDERTAKE TO BE LIABLE FOR ALL LEGAL COSTS, AS WELL AS TRACING/COLLECTION FEES DUE, SHOULD IT BE NECESSARY TO INSTITUTE LEGAL ACTION TO RECOVER AMOUNTS OWING ARISING OUT OF TREATMENT RECEIVED BY MYSELF OR ANY OF MY DEPENDANTS.*

DATE: _____________________________ SIGNED: _______________________________________