Dr Andy Zaidman
M.B.B.Ch (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: _____