J BRITZ **082 001 0330981**

SPEECH THERAPY AND AUDIOLOGY

Patient information form

Dear patient, the accounts for this practice are administered by Medsol. Kindly complete the document below in full in order for us to generate your account and submit to your medical scheme for processing. Please take a business card at reception and contact us directly should you have any account-related queries.

Details of patient

Surname		**Title**	
Full name(s)		**Gender**	**M | F**
Identity Number		**Date of birth**	
Cell phone		**Landline**	

Details of main member / person responsible for settling the account

Surname		**Title**	
Full name(s)		**Gender**	
Identity Number		**Date of birth**	
Postal address			
Residential address			
Work address			
Cell phone		**Home phone**	
Email address		**Work phone**	
Employer name		**Occupation**	

Details of your next of kin (person not living at the same address)

Surname		**Cell phone**	
Name		**Relationship**	

Details of your medical aid

Medical aid name		**Plan / Option**	
Dependant code (patient)		**Med. aid number**	
Planned admission date		**Auth. Number**	

Details of your referring doctor

Surname		**Practice number**	
First name(s)			

If the visit to this practice is an injury on duty, complete here

Employer name		**Injury date**	
Contact person		**Contact - landline and cell**	
Claim number			

Warranties

Upon signing this document, I warrant that:

I have read the General Terms and Conditions of Service for this Practice and fully understand the contents and implications thereof;

I bind myself and the patient detailed herein according to the provisions contained within the General Terms and Conditions of Service;

The details provided by me in this Patient Information Form are true and correct.

Signature

Main member / person responsible for settling the account sign here		**Place**	
		Date	