



Prof. Elaine Joseph

THE BREAST CARE & BONE
DENSITY CENTRE

PLEASE PRINT

MB. BCH(Rand) FFRAD(Diag)
SA. College of Radiology

PRACTICE. NO. 3804410
Reg No.

ACCOUNT No.

PATIENT INFORMATION

TITLE:	<input type="text"/>	SURNAME:	<input type="text"/>	SEX:	<input type="text"/>
FULL NAMES:	<input type="text"/>	AGE:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
RELATION TO MEMBER EG. FATHER MOTHER ETC.:	<input type="text"/>	EMAIL ADDRESS:	<input type="text"/>		
	<input type="text"/>	I.D. NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>
CELLPHONE NUMBER:	<input type="text"/>				

MAIN MEMBER / PERSON RESPONSIBLE

TITLE:	<input type="text"/>	NAME:	<input type="text"/>	SURNAME:	<input type="text"/>
I.D. NUMBER:	<input type="text"/>	MED. AID NAME:	<input type="text"/>	MED. AID NUMBER:	<input type="text"/>
POSTAL ADDRESS:			RESIDENTIAL ADDRESS:		
<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>		
CODE:			CODE:		
EMPLOYER (COMPANY NAME):			OCCUPATION:		
<input type="text"/>			<input type="text"/>		
TEL HOME:	<input type="text"/>	TEL WORK:	<input type="text"/>	CELL No.:	<input type="text"/>
EMPLOYER ADDRESS:			NAME AND TEL No. OF RELATIVE OR FRIEND:		
<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>		
CODE:			TEL No.:		
EMAIL ADDRESS OF MAIN MAMBER:			<input type="text"/>		
PAYING METHOD:	<input type="text"/>	CASH	<input type="text"/>	CASH	<input type="text"/>
NAME OF REFERRING DOCTOR:			TEL No.:		
<input type="text"/>			<input type="text"/>		
NAME OF YOUR GENERAL PRACTITIONER:			TEL No.:		
<input type="text"/>			<input type="text"/>		

DECLARATION

FEMALE PATIENT:			ALLERGIES:	YES	NO	PLEASE SPECIFY
ARE YOU PREGNANT?	YES	NO	ASTHMA:	YES	NO	

I HEREBY CONSENT TO THE INJECTION OR OTHER ADMINISTRATION OF ANY DRUG OR CONTRAST MEDIA WHICH MAY BE NECESSARY FOR THE PERFORMANCE OF MY X-RAY EXAMINATION, NOTWITHSTANDING ANY MEDICAL AID SOCIETY OR OTHER ORGANISATION'S UNDERTAKING. I ACKNOWLEDGE PERSONAL RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT WITHIN (30) DAYS, DIRECTLY TO THIS PRACTISE. IN THE EVENT OF NON-PAYMENT, I SHALL BE LIABLE FOR ALL LEGAL COSTS RELATING TO THE RECOVERY OF THE OUTSTANDING AMOUNT OF THE ATTORNEY AND OWN CLIENT SCALE AND INTEREST ON THE OVERDUE AMOUNTS CALCULATED AT A RATE EQUAL TO THE PRIME OVERDRAFT RATE CHARGED BY THE PRACTICE'S COMMERCIAL BANKERS.

NAME

SIGNATURE

WITNESS SIGNATURE

DATE

PLEASE NOTE THAT EVEN IF YOU ARE A MEMBER OF A MEDICAL AID FUND AND EVEN IF THE PRACTISE COLLECTS DIRECTLY FROM YOUR MEDICAL AID FUND, YOU REMAIN PERSONALLY RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT. IT IS YOUR DUTY AT ALL TIMES TO ENSURE THAT YOUR ACCOUNTS ARE PAID ON THE DUE DATE.

FOR OFFICE USE ONLY

<input type="text"/>	
CAPTURED BY:	<input type="text"/>
PRE-AUTHORISED:	<input type="text"/>