The Breast Care & Bone Density Centre

Dr Grace Rubin
THE BREAST CARE & BONE DENSITY CENTRE

MB. BCH FFRAD (Diag) MMed (RADD)
Wits University

PRACTICE. NO. 0131601
Reg No.

PLEASE PRINT

PATIENT INFORMATION

TITLE:		SURNAME:			SEX:		
FULL NAMES:		AGE:		DATE OF BIRTH:		LANGUAGE:	
RELATION TO MEMBER EG. FATHER MOTHER ETC.:			CELLPHONE NO:				
			I.D. NUMBER:				
EMAIL ADDRESS:							

MAIN MEMBER / PERSON RESPONSIBLE

TITLE:		NAME:		SURNAME:	
I.D. NUMBER:		MED. AID NAME:		MED. AID NUMBER:	

POSTAL ADDRESS:		RESIDENTIAL ADDRESS:	
	CODE:		CODE:

EMPLOYER (COMPANY NAME):		OCCUPATION:			
TEL HOME:		TEL WORK:		CELL No.:	

EMPLOYER ADDRESS:		NAME AND TEL No. OF RELATIVE OR FRIEND:	
	CODE:	TEL No.:	

EMAIL ADDRESS OF MAIN MAMBER:				
PAYING METHOD:	CARD		MEDICAL AID	

NAME OF REFERRING DOCTOR:		TEL No.:	
NAME OF YOUR GENERAL PRACTITIONER:		TEL No.:	

DECLARATION

FEMALE PATIENT:		
ARE YOU PREGNANT?	YES	NO

ALLERGIES:	YES	NO	PLEASE SPECIFY
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

CAPTURED BY:		PRE-AUTHORISED:	