

MAIN MEMBER INFORMATION:

ID NUMBER: \_\_\_\_\_ SURNAME: \_\_\_\_\_

FULL NAMES: \_\_\_\_\_ GENDER:  MALE  FEMALE

HOME LANGUAGE: \_\_\_\_\_ TITLE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CELL NUMBER: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

PHYSICAL ADDRESS:

\_\_\_\_\_

\_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

MEDICAL SCHEME: \_\_\_\_\_ PLAN / OPTION \_\_\_\_\_

MEMBER NO: \_\_\_\_\_ GAP COVER:  Y /  N DEP. CODE \_\_\_\_\_

**PATIENT INFORMATION:**

ID NUMBER: \_\_\_\_\_ SURNAME: \_\_\_\_\_

FULL NAMES: \_\_\_\_\_ DEPT. CODE \_\_\_\_\_  MALE  FEMALE

HOME LANGUAGE: \_\_\_\_\_ TITLE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CELL NUMBER: \_\_\_\_\_ HOME NUMBER: \_\_\_\_\_

WORK NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ RELATIONSHIP TO MAIN MEMBER: \_\_\_\_\_

REFERRING DR: \_\_\_\_\_ TEL NR: \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_ TEL NR: \_\_\_\_\_

**PATIENT CONSENT CLAUSE TO PROCESS PERSONAL INFORMATION**

I hereby consent to the processing of my personal information contemplated in the protection of Personal Information Act No 4 of 2013, by Dr IPS Terblanche the practice staff and third parties with whom Dr IPS Terblanche has a contractual relationship for the following purposes:

- A Treating and managing me in terms of a doctor and patient relationship.
- B The Administration of the contractual relationship between myself and Dr IPS Terblanche.
- C Communicating with other persons in as much as it relates to my treatment and management.
- D Communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof including medical schemes and their administrators where relevant.
- E Collecting monies outstanding from me.

I understand the implication and agree that, where appropriate, the healthcare professional and practice may disclose my ICD-10 diagnosis code (s) under the conditions described above.

Hereby I confirm that the information I supplied is true and I am responsible for any false information provided.

PLEASE NOTE THIS PRACTICE CHARGES PRIVATE FEES:

I ACKNOWLEDGE PERSONAL RESPONSIBILITY FOR PAYMENT OF ACCOUNTS TO THIS PRACTICE. IN THE EVENT OF NON-PAYMENT.

I SHALL BE LIABLE FOR ALL LEGAL COSTS IN THE COLLECTION OF THE OUTSTANDING AMOUNT ON THE ATTORNEY AND CLIENT SCALE. INTEREST CHARGED ON OVERDUE ACCOUNTS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_