Dr. Sampie Smith

MP 059 0983 PRAKTYKNR. 042 0000 443212 M.B.CH.B M.MED(CHIRURGIE) UOVS

SPECIALIST SURGEON SPESIALIS CHIRURG

Patient Particulars

Surname:_____

Full names: (Mr./Mrs./Ms.):_____

ID number:_____

Telephone number: Home:_____ Work:_____

Cellular:_____ Fax:_____

E-mail address:_____

Occupation:_____

Name and address of employer:_____

Name and address of next-of-kin:_____

Contact number of next-of-kin:_____ Relationship:_____

Referring Dr:_____

Particulars of person responsible for payment of services rendered

(All consultations are payable on the service date, see document "Practice billing policy and patient responsibilities")

Surname:_____

Full names: (Mr./Mrs./Ms.):_____

ID number:_____

Postal address:_____

Residential address:_____

E-mail address:_____

Telephone number: Home:_____ Work:_____

Cellular:_____ Fax:_____

Medical aid:_____ Number:_____

Medical aid plan/option:_____

Authorisation number for consultation (if required by your medical aid):_____

Occupation:_____

Name and telephone number of employer:_____

Work address:_____

I, the undersigned, hereby declare that all the above-mentioned information is just and true. I accept all responsibility for payment of the full outstanding amount, if not settled by my medical aid/-scheme within 60 days and for payment of any legal expenses due to non-payment of any accounts on attorney and client scale. I declare that I was informed that my medical aid/-scheme might require personal information with regards to my account from time to time and I grant the necessary permission that the requested information can be sent to the medical aid/-scheme in order to assure/speed-up the payment of my account. I grant permission to Dr Sampie Smith Inc. to contact me using the above contact information provided with regards to account and medical queries.

Signature:_____ Date:_____