Dr's N & E Burger

50 Main Road
Muizenberg, 7945

BChD
Dentists/Tandartse

Tel: 021 788 8685
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info@muizenbergmedical.co.za

Practice no: 048 4490

PATIENT DETAILS

Title:……..Surname:……..……..Dependant code:……..……

First names:……

ID no:…… Date of birth:……..……

Postal address:……

……Code:……

Home address:……

……Code:……

Tel: (H)……..……..(W)……..(C)……..……

Email address:……

Occupation:……..Employer:……

Work address:…… ……

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Medical Aid:…….. Medical Aid no:……

Medical Aid Plan/Option:……..

SPOUSE

Full names:……..Dependant code:……..

ID no.:…… Date of birth:……..……

Employer:……Work address:……..……

……..Code:……

Tel: (W)……(C)……

PERSON RESPONSIBLE FOR ACCOUNT

Tick the box if same as patient: ☐

Full names:…… Dependant code:……

ID no:……..……Date of birth:……..

Employer:……Work address:……..……

……...Code:……..

Tel: (H)…….. (W)…….. (C)……..……

DEPENDANTS

Dependant code	Full names	ID or Date of Birth

NEXT OF KIN (Emergency contact)

Names:……

Tel: (H)……..(W)……..(C)……..

Home address:……

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……Code:……

P.T.O.

TERMS AND CONDITIONS OF SERVICE

1. I, the undersigned, am aware of the fact that the agreement for rendering professional service is between the dentist and myself and that my medical aid, if any, is not contractually bound with the dentist. I also undertake to follow up on the account myself and to settle it in full on 30 calendar days from the date of service – if the medical aid does not settle it by then.
2. If I have a valid medical aid, I give permission for the account with the ICD10- codes to be sent to the medical aid.
3. In the event of legal action being instituted against me, I agree to pay all the costs on attorney and client scale, including collection, commission and tracing fees.
4. All private costs are payable immediately. I undertake to tend to it as such unless otherwise arranged.
5. All cancellations less than four hours before the appointment would be liable for a late cancellation fee of R250.
6. I confirm that all the given details are correct at the time of signing the document. I will let the practice know in writing if any detail should change.
7. Consent to 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 Muizenberg medical practitioners, practice staff and third parties with whom the Practice 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 Muizenberg Medical;
   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 cost of my treatment and management or part thereof, including medical schemes and their administrators where relevant; and
   e-Collecting monies outstanding from us

   (Muizenberg medical practitioners referring to – Dr's Nelanie and Este Burger)

8. I have read and understood the terms of service delivery.

Name:……

Signed:……..

Date:……..

Name:	YES	NO
Any Allergies?		
If yes, please specify allergy:		
High blood pressure?		
Pregnant?		
Have you had any of the under mentioned conditions?		
Rheumatic fever as a child?		
Cardiac bypass or "stents"?		
Hip or knee-replacements?		
Heart valve replacement or pacemaker?		
Gastric ulcers or chronic heartburn?		
Epilepsy?		
Asthma?		

Any important information regarding your medical background that is not mentioned in the above questionnaire?

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