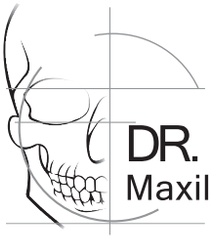

DR. HENNIE KLOPPERS
Maxillofacial & Oral Surgeon

Cell: 071 403 2203
Tel: (011) 472 2361/21
E-mail: admin@jhbmaxillofacial.co.za
accounts@jhbmaxillofacial.co.za
Pr. No. 0666327

PASIËNT BESONDERHEDE / PATIENT DETAILS

Van: Surname:		Beroep: Occupation:
Volle Naam: Full Names:		Taal: Langauge:
I.D. Nr: I.D. No:	Geboortedatum: Date of Birth:	Huwelikstatus: Marital Status:
Pasiënt epos: Patient email:		

Woonadres: Home Address:	Poskode: Postal Code:

Tel. (H):	Tel. (W):	Sel: Cell:

PERSOON VERANTWOORDELIK VIR REKENING / PERSON RESPONSIBLE FOR ACCOUNT

Hooflid se Voorletters & Van: Main Members Initials & Surname:	
Hooflid se I.D. Nr: Main Members I.D. No:	E-Pos: E-Mail:
Woonadres: Home Address:	Poskode: Postal Code:
Posadres: Postal Address:	Poskode: Postal Code:

Tel. (H):	Tel. (W):	Sel: Cell:

MEDIESE FONDS BESONDERHEDE / MEDICAL AID DETAILS

Mediese Fonds Naam: Name of Medical Aid:	Nr: No:
Opsie / Plan: Option / Plan :	Afh. Kode pasiënt: Dep. Code patient:
Hooflid se Volle Naam & Van: Main Member Full Name & Surname::	Verwantskap pasiënt: Relationship patient:

NAASBESTAANDE (nie woonagtig by dieselfde adres nie) / NEXT OF KIN (not living at same address)

Van & Voorletters: Surname & Initials:	Verwantskap: Relationship:
Woonadres: Home Address:	Poskode: Postal Code:

Tel. (H):	Tel. (W):	Sel: Cell:

REGARDING YOUR ACCOUNT:
This practice does not charge fees according to medical aid rates. We are only contracted to Discovery Medical Aid and this practice charges fess according to Discovery Rates. Disregarding the fact that you are on a medical aid or not, you are responsible to pay your account in full within 30 days, failing which interest shall be charged on any outstanding amount at 1.5% per month, and if collection steps have to be initiated you will be liable for such costs, including legal costs on attorney and own client scale.

IMMEDIATE SETTLEMENT OF FEES APPLY TO THE FOLLOWING:
All consultations, X-rays, photos, all local procedures, all private patients and patients with no medical aid coverage, all co-payments and all implant material costs. All these costs must be fully settled prior to any operation. Any account electronically submitted to a medical aid, which is unpaid by your medical aid, for whatever reason, shall become immediately payable by you in full, If your account is not fully settled within 30 days, after you've been notified, your account will be handed over for legal processing. All costs and charges including costs on an attorney and own client legal scale, incurred by the practice in exercising its right in terms of the terms and conditions, as well as interest at a rate of 1.5% per month, will be added to your account.

By completing this patient form, I hereby consent and agree to the terms and conditions associated with the practice, a copy of which is attached hereto. The practice reserves its right to update the terms and conditions and onus is on the user to keep abreast of all the changes and updates that occur from time to time.

I hereby certify that the information on this form is true and correct. I acknowledge that it is my responsibility as member/petient to inform the practice if any of the above details change.

I further agree to all arrangements regarding my account and the payment of my account.

Van & Voorletter van Persoon Verantwoordelik vir Rekening /
Surname & Initials of person Responsible for account

Titel:
Title: .....
Verwantskap:
Relationship: .....
Handtekening:
Signature: .....
Datum:
Date: .....

MEDIESE GESKIEDENIS / MEDICAL HISTORY

JA YES	NEE NO	MERK TOEPASLIKE BLOKKIE MARK RELEVANT BLOCK
		HARTSIEKTES / HEART DISEASE
		LONG SIEKTES / LUNG DISEASE
		HOË BLOEDDRUK / HIGH BLOOD PRESSURE
		ALLERGIEË / ALLERGIES (Medikasie / Medication)
		PORFIRIË / PORPHYRIA
		BLOEDINGSNEIGING / BLEEDING TENDENCIES
		LEWERSIEKTE / LIVER DISEASE (Geelsug / Jaundice)
		SUIKERSIEKTE / DIABETES
		HORMOON WANBALANS / HORMONAL IMBALANCE
		NIERSIEKTE / KIDNEY DISEASE
		RUMATIEKKOORS / RHEUMATIC FEVER
		GEWRIGSONTSTEKING / ARTHRITIS
		BEROERTE / STROKE
		EPILEPSIE / EPILEPSY
		ASMA / ASTHMA
		SIELKUNDIGE BEHANDELING / PSYCHIATRIC TREATMENT
		DAMES: IS U SWANGER? (HOEVEEL WEKE?) / LADIES: ARE YOU PREGNANT? (HOW MANY WEEKS)
		HIV POSITIEF / POSITIVE
		IS U AL GETOETS VIR HIV / HAVE YOU BEEN TESTED FOR HIV
		VORIGE NARKOSE / PREVIOUS ANAESTHETIC
		PROBLEME / PROBLEMS
		ENIGE ANDER SIEKTES OF MEDIKASIE / ANY OTHER DISEASE OR MEDICATION

Handtekening:
Signature: _____

Datum:
Date: _____

INFORMED CONSENT:
(only applicable to patients who have to receive a surgical procedure)

I, (the patient or guardian in case of a minor) _____ , have been consulted in this regard. I have received all instructions regarding post - operative symptoms associated with this operation, and have been informed about possible complications related to the procedure. I have also received an estimate regarding the cost involved and I agree to the cost and payment involved.

Operation 1: _____ Date: _____ Sign: _____

Operation 2: _____ Date: _____ Sign: _____

Operation 3: _____ Date: _____ Sign: _____