Dr. Dewald Coolen
SPECIALIST SURGEON

PERSON RESPONSIBLE FOR ACCOUNT

Surname:		Title:		
Full Names:		Gender:	Male	Female
Date of Birth:	ID nr:			
Postal Address:	Physical address:			
Postal Code:	Postal Code:			
Tel: (H)	Cell:			
Employer:	Occupation:			
Employer's Address:				
		Postal Code:		
Tel: (W)	Email address:			
Medical Aid:	Medical Aid No:			
Medical Aid Option:	M/M dependant code:	Benefits:	Hospital	Full
Gap cover details:		If applicable:	Yes	No
Friend / Family (not at same physical address):		Cell: Tel:		
Physical Address:		Relation:		

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Suite 13, Block 3, Second Floor, Vergelegen Medi Clinic, Main Road, Somerset West 7130
Postnet Suite 92, Private Bag X15, Somerset West 7129
Practice No: 042 000 036 8210 | Vat No: 444 025 7873 | Inc No: 2010/008783/21

PATIENT'S DETAILS

Surname:	Title:		Dep Code:
Name:		Relation to Main Member:	
Date of Birth:	ID nr:		
Tel. (H / W)	Cell:	Email:	
Address:			
			Postal Code:
REFERRING DOCTOR:			

LIABILITY

I confirm that the information supplied is true. I agree that it is the responsibility of the member to obtain pre-authorisation for procedures. The member will carry all costs/penalties incurred as a result of failed pre-authorisations. I further understand that the member is personally responsible for settlement of the account, and if applicable for submission thereof, to the medical aid. Should legal steps be instituted for collection of this, I shall be liable for the costs on an attorney/client scale.

I hereby give consent that the ICD 10 codes of my examination(s) may be disclosed to my medical aid and referring doctors.

PLEASE NOTE: ***This practice charges Private rates.***

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NAME (PRINT) **SIGNATURE** **DATE**