

**MAIN MEMBER INFORMATION:**

* ID NUMBER:	<input type="text"/>	* SURNAME:	<input type="text"/>
* FULL NAMES:	<input type="text"/>		
INITIALS:	<input type="text"/>	GENDER:	<input type="checkbox"/> M <input type="checkbox"/> F
TITLE:	<input type="text"/>	* DATE OF BIRTH:	<input type="text"/>
HOME LANGUAGE:	<input type="text"/>		
* CELL NUMBER:	<input type="text"/>	HOME NUMBER:	<input type="text"/>
WORK NUMBER:	<input type="text"/>	EMPLOYER:	<input type="text"/>
FAX NUMBER:	<input type="text"/>		
E-MAIL ADDRESS:	<input type="text"/>	E-MAIL STATEMENT?	<input type="checkbox"/> Y <input type="checkbox"/> N
* POSTAL ADDRESS:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	* POSTAL CODE:	<input type="text"/>
PHYSICAL ADDRESS:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	POSTAL CODE:	<input type="text"/>
* MEDICAL SCHEME:	<input type="text"/>		
* PLAN/OPTION:	<input type="text"/>	GAP cover:	<input type="checkbox"/> Y <input type="checkbox"/> N
* MEMBER NO.:	<input type="text"/>	MAIN MEMBER DEP CODE:	<input type="text"/>

**PATIENT INFORMATION:**

* ID NUMBER:	<input type="text"/>	* SURNAME:	<input type="text"/>
* FULL NAMES:	<input type="text"/>	NICK NAME:	<input type="text"/>
INITIALS:	<input type="text"/>	GENDER:	<input type="checkbox"/> M <input type="checkbox"/> F
TITLE:	<input type="text"/>	* DATE OF BIRTH:	<input type="text"/>
HOME LANGUAGE:	<input type="text"/>		
CELL NUMBER:	<input type="text"/>	Use this number for appointments / test results	<input type="checkbox"/> Y <input type="checkbox"/> N
		<i>Main member's Cell Phone number will be used if the above is No</i>	
HOME NUMBER:	<input type="text"/>	WORK NUMBER:	<input type="text"/>
E-MAIL ADDRESS:	<input type="text"/>		
OCCUPATION:	<input type="text"/>	MARITAL STATUS:	<input type="text"/>
RELATIONSHIP TO MAIN MEMBER:	<input type="text"/>	* PATIENT DEP CODE:	<input type="text"/>
AGE:	<input type="text"/> years	HEIGHT:	<input type="text"/> , <input type="text"/> m
WEIGHT:	<input type="text"/> kg		
REFERRING DR:	<input type="text"/>	TEL:	<input type="text"/>

**NEXT OF KIN:** (Not from the same physical address)

INITIALS:	<input type="text"/>	TITLE:	<input type="text"/>	SURNAME:	<input type="text"/>
FULL NAMES:	<input type="text"/>				
CELL NUMBER:	<input type="text"/>	RELATIONSHIP TO PATIENT:	<input type="text"/>		

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

* NAME IN PRINT:	<input type="text"/>
* DATE OF SIGNATURE:	<input type="text"/>
* SIGNATURE:	<input type="text"/>
Allow mass communication or notices from practice	<input type="checkbox"/> Y <input type="checkbox"/> N

**All fields with \* are mandatory. Please note that you (or your parent/guardian) remain liable for the account for services rendered by this practice, even if you are insured by a medical aid or other third party. Please ensure that you have read and signed the attached Doctor-Patient contract.**