FILE NO: (Office use only)	

I. PATIENT'S PERSONAL INFORMATION:

SURNAME:	**TITLE:**	**INITIALS:**
FULL NAMES:		
ID NO:	**DATE OF BIRTH:**	
HOME LANGUAGE:	**MARITAL STATUS:**	
OCCUPATION:		
EMPLOYER:		
HOME TEL NO:	**WORK TEL NO:**	**CELL NO:**
EMAIL ADDRESS:		
RESIDENTIAL ADDRESS:	**POSTAL ADDRESS:**	
	CODE:	

II. MAIN MEMBER | PERSON RESPONSIBLE FOR THIS ACCOUNT - (If not the patient):

SURNAME:	**TITLE:**	**INITIALS:**
FULL NAMES:		
ID NO:	**DATE OF BIRTH:**	
EMPLOYER:		
HOME TEL NO:	**WORK TEL NO:**	**CELL NO:**
EMAIL ADDRESS:		
RESIDENTIAL ADDRESS:		**CODE:**

III: MEDICAL AID INFORMATION:

MEDICAL AID SCHEME:	**PLAN:**
MEMBERSHIP NO:	**AUTH / REF. NO: (ONLY IF NOT REFERRED FROM GP OR SPECIALIST)**
DEPENDANT CODE:	

IV: REFERRED BY:

NAME:		
ADDRESS:		
	CODE:	**TEL NO:**

V: EMERGENCY CONTACT (Person to be contacted in case of a medical emergency and medical accounts):

SURNAME:	**NAME:**	
RELATIONSHIP TO PATIENT:		
CELL NO:	**EMERGENCY CONTACTS ADDRESS:**	
WORK NO:		
HOME NO:		**CODE:**
EMAIL:		

PLEASE TURN OVER

PLEASE NOTE:

- **PRIVATE PATIENTS –** Are required to settle their accounts in full after their consultation (Fees charged at Medical Aid rates).

- **MEDICAL AID PATIENTS** – Please consult with your medical aid prior to your appointment to obtain an authorization or reference number as per scheme rules. The fees charged are contracted in with the Medical Aids.

  NB : Patients making use of foreign medical aids (e.g. **Botswana, Namibia, Swaziland**, etc.,) are required to settle their accounts in full after the consultation. We will provide you with a detailed statement and receipt so that you are able to claim back from you medical aid.

- Fees will be levied for the writing of repeat prescriptions, motivations, completing of chronic medication forms and telephone consultations.

- As a service, this practice submits all claims electronically to the medical aids, **however, the patient remains fully responsible for his/her account and not the medical aid**.

- The patient is given **60 days** in which to settle his/her account in full.

- If payment is not made within **60 days**, the account will be handed over to our attorneys for collection.

- Due to the unreliability of the postal service, all accounts will be emailed, faxed and/or smsed to the person responsible for the account.

I, Dr/Prof/Mr/Mrs/Miss _____, hereby declare that the information I have provided is true and correct and agree to the terms and conditions as set out above.

Patient Signature: _____ **Date:**_____

Guarantor Signature: _____ **Date:** _____
(Person Responsible for the account)

PLEASE TURN OVER

Dr Louis P Wilken

ALGEMENE INTERNIS / SPECIALIST PHYSICIAN
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Fax :(012) 348 2437

PATIENT CONFIDENTIALITY DISCLOSURE CONSENT FORM

I, the undersigned …… (Full name and surname), as

Patient ☐ / Legal Guardian ☐

Identity Number: ……,

hereby authorise Dr Louis Phillippus Wilken and/or staff member nominated by him, who is in possession of information concerning my medical diagnosis and treatment together with my health and personal particulars to disclose such information to my Healthcare Funder and other Healthcare Providers.

I wish to further indicate that such permission to disclose such information is only for the purpose of treatment and management of my medical condition.

I wish to further indicate that this consent was given out of my own free will without any undue influence from Dr Louis Phillippus Wilken and/or staff member nominated by him.

Signed at Pretoria, on this …… day of …….. 20……..

_____ _____

Signature of patient / Legal Guardian **Witness**