(dd/mm/yyyy)

Room 104, Mediclinic Midstream Hospital

E-mail:
reception@PretoriaENT.com
accounts@PretoriaENT.com

Phone:
Landline: 012 652 9555
Mobile: 084 334 8284

Patient Information

Personal Information

Patient Names and Surname:
If minor, state name of parent or guardian:
Date of Birth (dd/mm/yyyy):
Gender: Please select
Referring Doctor:

Have you been in a hospital in the past two years?	○ Yes	○ No
Have you been under the care of a doctor during the past two years?	○ Yes	○ No
Any medicine or drugs during the past two years?	○ Yes	○ No
Are you allergic to Penicillin / any other drugs or medicine?	○ Yes	○ No
Have you had any excessive bleeding requiring special treatment?	○ Yes	○ No

Tick the name of any of the following which you have had

☐ Heart Disease	☐ Heart Murmur	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Cough	☐ Diabetes	☐ Tuberculosis
☐ Hepatitis	☐ Jaundice	☐ Arthritis	☐ Stroke
☐ Epilepsy	☐ Psychiatric Treatment		

Have you had any other serious illnesses?	○ Yes	○ No
If Applicable: Are you pregnant?	○ Yes	○ No

Person responsible for payment of account / main member:

Names and Surname: (with title)
ID Number:
Home Address:
Postal Address:
Home Tel:
Work Tel:
Cell:
Email:
Medical Aid:
Medical Aid Plan:
Medical Aid Number:
Authorization Number:

Other Telephone Numbers:

Wife / Mother:
Husband / Father:
Relative / Friend:

Agreement

I, _____ (name of person responsible for account) undertake to pay all costs as between attorney and client as well as collection commission of 10% . In the event of instituting any legal action emanating from this document / transaction against me/us. I agree to pay any account received within 30 (thirty) days of statement date and acknowledge that I will pay the interest per month on any unpaid balance owing by me.

Signature: ..... Date (dd/mm/yyyy):

IMPORTANT NOTICE: PLEASE READ INFORMATION REGARDING TARRIFS.
PLEASE NOTE, WE ARE NOT CONTRACTED TO ANY MEDICAL AID