DR. BARBARA SCHOLZ

Specialist Physician /Gastroenterologist

MBChB (Stell); DA, HIV Dip Man (SA); MRCP II (Edin); FCP(CMSA); Certificate Of Gastroenterology (CMSA)

Practice No. NL 0180000363227.
HCPNA: MPR01551

Account Number

MAIN MEMBER OF MEDICAL AID / PERSON RESPONSIBLE FOR THE ACCOUNT

Surname:	First Names:
ID Number:	Title:
Home Address:	Postal Address:
Home Telephone:	Cell:
E-mail:	Spouse's Cell:
Work Telephone: Ext:	Spouse's Work Telephone:
Employer:	Fax Number:
Position in firm:	

PATIENT DETAILS

Surname:	First Names:
ID / PP No:	Date of Birth:
Occupation:	Married: YES NO
Home Language:	Preferred Language: Afrikaans English
Cell Number:	Allergies:
Referred by:	
Who is your GP?	

MEDICAL AID DETAILS

Name of Fund:	Option:	Number:
Do you have a: Trauma Plan?	Hospital Plan?	
Details:		

BANKING DETAILS IN CASE OF REFUND

Bank:	Account Name:
Account Number:	Branch Code:

WHO TO CONTACT IN CASE OF AN EMERGENCY (NOT FROM THE SAME HOUSEHOLD)

Name and Surname:		Relationship with Patient:	
Telephone: Work:		Home:	Cell:

INJURY ON DUTY (WCA)

Accident report available: YES NO	Date of accident: / / 20
Contact Person:	Division:

I confirm that the above information is true and correct and undertake to inform the practice of any changes thereto within 14 days of a change occurring.

I undertake to forward all accounts to my medical aid scheme and to settle all accounts that have not been paid by them.

I understand that:

- *24% Interest will be charged on all outstanding amounts after 60 days.*
- *I will be held responsible for all administration and collection fees.*
- *In the event of non-payment by 90 days, my name will be black-listed and registered with ITC.*

I take full responsibility for the account.

Signature: ..... Date: .....

Afrikaans op keersy

prime press 012016