247 GP

Patient Registration Information (Please write legibly to ensure accurate data capturing)

DETAILS OF MAIN MEMBER (Person responsible for account and/or main member of medical aid [if applicable])	
SURNAME:	
FULL NAME (s):	TITLE:
ID/PASSPORT NUMBER:	
CELLPHONE NUMBER:	
HOME TELEPHONE NUMBER:	
WORK TELEPHONE NUMBER:	
EMAIL:	
RESIDENTIAL ADDRESS:	CODE:
POSTAL ADDRESS:	CODE:

MEDICAL AID DETAILS (IF APPLICABLE)	
MEDICAL AID NAME:	
OPTION:	
MEDICAL AID NUMBER:	

DEPENDANTS (AS REGISTERED WITH MEDICAL AID, IF APPLICABLE)**/**
FAMILY MEMBERS (TO BE REGISTERED IN MEDICAL FILE)

DEP. NO.	FULL NAME (& SURNAME IF DIFFERENT)	MALE/ FEMALE	ID NUMBER/ DATE OF BIRTH	CONTACT NUMBER & EMAIL (IF DIFFERENT FROM ABOVE)
		M		
		F		
		M		
		F		
		M		
		F		
		M		
		F		
		M		
		F		

FAMILY DOCTOR'S CONTACT DETAILS

NAME:		OFFICE TELEPHONE:	
EMAIL:			

NEXT OF KIN

NAME:		NAME:	
CELLPHONE NUMBER:		CELLPHONE NUMBER:	
HOME TELEPHONE NUMBER:		HOME TELEPHONE NUMBER:	
WORK TELEPHONE NUMBER		WORK TELEPHONE NUMBER:	
RELATIONSHIP:		RELATIONSHIP:	

AGREEMENT BY PATIENT

I understand that payment of services rendered remains my responsibility. I agree that should my account be handed over for collection, I shall be liable for all attorney and own client fees, collection charges and all disbursements. I agree that the account and payment of account is subject to the prescribed Rate of Interest Act and that I remain liable for mora interest on accounts that have not been settled within 30 days. I agree to inspection of and negative listing of my credit information should my account timeously. I choose the above address as my domicilium citandi et executandi for all purposes in terms of this agreement.

Furthermore, I hereby declare that the above information furnished by me is true and correct in all respects.

Signature:	Date: /20