THE BONE & BREAST CARE CENTRE

PATIENT INFORMATION:

TITLE: _____

SURNAME _____

FULL NAMES: _____

ID NUMBER: _____

DATE OF BIRTH: _____

RELATIONSHIP TO MEMBER OF MED. AID: _____

OCCUPATION: _____

EMPLOYER: _____

WORK TEL. NO: _____

MEMBER INFORMATION:

TITLE: _____

INITIALS: _____

SURNAME: _____

ID NUMBER: _____

OCCUPATION: _____

EMPLOYER: _____

WORK TEL.NO. _____

Please fill in the MEDICAL AID details:

MEDICAL AID NAME: _____

MEDICAL AID NO.: _____

POSTAL ADDRESS: _____

_____

_____

_____

_____

TEL HOME: _____

PATIENT CELL NO.: _____

E-MAIL ADDRESS: _____

REFERRING DOCTOR: _____

REFERRING DOCTOR: _____

HOME ADDRESS: _____

_____

_____

_____

_____

RELATIVE/FRIEND NAME: _____

TEL: _____

REFERRING DOCTOR: _____

REFERRING DOCTOR: _____

Where did you hear about The Bone & Breast Care Centre: _____

I hereby give consent for injection or other administration of any drugs or contrast media which may be necessary for the performance of my X-Ray examination. I ACKNOWLEDGE PERSONAL RESPONSIBILITY FOR PAYMENT of the account. In the event of non-payment I shall be liable for all legal costs in the collection of the outstanding amount on the attorney and client scale. interest may be charged on overdue accounts.

PLEASE TAKE NOTE THAT WHILST EVERY CARE IS TAKEN IN DOING A MAMMOGRAM, THE MAMMOGRAM BY ITS NATURE MAY CAUSE DAMAGE TO PROSTHESES AND WE CANNOT ASSUME LIABILITY FOR ANY DAMAGE TO SAME.

IT IS ESSENTIAL THAT YOU ADVISE US BEFORE HAVING A MAMMOGRAM IF YOU ARE PREGNANT.

By signing this declaration, I acknowledge that in providing health and/or medical services to me, it is necessary for the doctor providing treatment to me to process my personal information for purposes of providing Services to me. I further provide my consent to the doctor to share such personal information as may be necessary with other doctors who may be involved in my treatment, including my medical aid for purposes of processing claims for payment.

_____ _____

DATE SIGNATURE