Dr. Megan Jones

PATIENT DETAILS:

Surname:	Name:	Title:
Occupation:	Marital status:	
ID number:	Home language:	
If minor (under 18) Contact Person's Name:	Contact/Emergency Person's Phone No.:	
Home Address:	Postal Address:	
Tel. (H):	Tel. (W):	
Cell:	Email:	
Referred by:	Employer:	

Current Medication:	Allergies:

PERSON RESPONSIBLE FOR PAYMENT:

Full name:	Tel. (H): Tel. (W):
Postal Address:	

MEDICAL AID DETAILS:

Name of Medical Aid:	No.:
Principal Member:	

PLEASE NOTE:

1. You are responsible for payment of this account as this practice is contracted out of Medical Aid Schemes. Please settle your account then forward on to your Medical Aid for re-imbursement.
2. Ensure that you are fully aware of possible costs before finalizing a service so that alternative arrangements can be made.
3. Notice of cancellation of an appointment is to be made 24hours PRIOR to the appointment, failing which a consultation fee will be levied.
4. I, ... certify that the above information is correct and accept responsibility for settlement of account. Should I fail to settle this account, I further undertake to pay legal costs relating to the recovery of the outstanding money in respect of professional services rendered, including attorney/client fees, collection commission and trading costs.

....

Signature Date