DR. ELIZE WETHMAR – PATIENT PAYMENT DETAILS FORM

MEDICAL AID INFORMATION

Medical Scheme	
Plan/Option	
Member Number	
Start Date	
Dependant Code	
GAP Cover	

MAIN MEMBER INFORMATION

ID Number	
Surname	
Full Names	
Initials	Title:
Birth Date	Male / Female
Home Language	
Cell Number	Work Number:
Home Number	
Employer	
Email Address	
Postal Address	Postal Code:
Physical Address	Postal Code:

PATIENT INFORMATION

ID Number	
Surname	
Full Names	
Initials	Title:
Birth Date	Female / Male
Home Language	Marital Status:
Cell Number	Work Number:
Home Number	
Occupation	
Email Address	
Relationship M/Member	
Dependant Code	
Referring Doctor	
Telephone Number	

DECLARATION

I, (Full Name of Patient)_____ hereby declare that the above information I have supplied is true and I am responsible for any false information provided. I (or my parent/guardian) remain liable for the account for the services rendered by Dr Elize Wethmar and her practice, even if I am insured by a medical aid or another third party. I have read and signed all the terms and conditions.

SIGNATURE:_____Date:_____