NO:_____

WELCOME TO DR THERESA JORDAAN'S PRACTICE

PATIENT PERSONAL INFORMATION

First Name_____Preferred name *(if different from above)* _____

Surname_____

Title_____ Initials_____ Gender__M__F Date of Birth_____

Identity number *(if South African)*_____

Home Language_____ Occupation_____

Home Address_____

Postal Address *(if different from above)*_____

Home phone number _____Work number_____ to be used for practice correspondence only

Cell phone number _____ to be used for practice correspondence only

Email _____ to be used for practice correspondence only

DO YOU USE Daily/Chronic medication : YES / NO If you do please inform reception

NB!!!! Do YOU have any Allergies for medication : YES / NO If you do please inform reception

EMERGENCY CONTACT

In case of emergency, whom would you like us to contact?

Name_____Initials_____ Title_____

Cell phone number_____ Relationship_____

Main Member Details / Person responsible for account :

First Name_____

Surname_____

Title_____ Initials_____ Gender__M__F Date of Birth_____

Identity number *(if South African)*_____

*Relation to the patient*_____ *Occupation*_____

Cell phone number _____to be used for practice correspondence only

Email _____ to be used for practice correspondence only

MEDICAL AID DETAILS -FIRST CONSULTATION PAYABLE ON THE DAY

CASH CONSULTATION PAYABLE ON THE DAY UNLESS PRIOR ARRANGEMENT MADE WITH PRACTICE MANAGER

Medical aid Name:_____

Medical option/plan:_____

Medical aid Number:_____

Please tick if applicable : **Hospital Plan_____ Private / Cash_____**

Dependant Details:

Name	Surname	Date of Birth/ ID Number	M/F

All personal information are kept according to POPIA guidelines

PLEASE READ AND SIGN BACK OF DOCUMENT

MUST READ

Dr Theresa Jordaan
General Practitioner
Pr no: 0491713

The practice may charge more than the rates that the Department of Health has determined for doctors. The Reference price list is available from the Department of Health (Tel: 012 312 0000) and the HPCSA (Tel: 012 338 9300 and www.doh.gov.za

You must inquire about consultation fees and in-consultation-room special investigation fees (e.g. ECG, Pap smear, Counselling consult, Incisions, etc.), prior to having the investigations performed.

Special investigations and medications are not included in the basic consultation fee. The need for additional special investigations are individualized and based on the expertise and clinical judgement of the attending doctor.

The treating doctor nor the practice is liable for supplying fee information or additional in-hospital and out-of-consultation-room special investigations for which patients are referred (e.g. Blood tests, Radiology investigations Specialist investigations etc.). It is the patients responsibility to inquire about the in-hospital and out-of-consultation-room special investigation fees prior to having the investigation, with the appropriate department. The treating doctor nor the practice can be held liable for any accounts related to additional investigations for which patients are referred.

Feel free to discuss any objections or queries about any additional special investigations requested with the doctor.

Accounts can be submitted to certain medical aids. The patient is responsible for ensuring contact and account details are correct and up to date. The patient remains responsible for the account and balance owing to the account in spite of being a member of a medical aid. Patients can settle accounts either by cash or card facilities on day of consultation

Practice Consulting Hours

Monday – Friday
09h00-17h00
Saturday
09h00-12h00

We try to accommodate late arrivals wherever possible, *but* when fully booked and appointment is late we may have to cancel and or reschedule.
We ask that in the event of a cancellation that it be done two hours prior to appointment or a fee may be charged. This will apply to all appointments..

I, _____, have read, understand and agree to the above practice terms and conditions.

Patient Name Surname _____

By signing this form you give the treating GP permission to share your information to the pathologist in the event of pathology sample sent, radiologist or specialist for referrals to be done. This will be for all dependants stated on this patient information form.

Person responsible for account Signature:

_____ **Date: ____/___/ _____**

Thank you