

MEDICAL DETAILS

PERSON RESPONSIBLE FOR ACCOUNT

FULL NAME AND SURNAME MR MRS MISS

DATE OF BIRTH IDENTIFICATION NO. MARITAL STATUS

PHYSICAL ADDRESS

HOME TELEPHONE WORK TELEPHONE

POSTAL ADDRESS POSTAL CODE

HUSBAND CELLPHONE

WIFE CELLPHONE

WIFE WORK TELEPHONE

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

MEDICAL AID

NAME OF MEDICAL AID MEDICAL AID PLAN MEDICAL AID NO.

DEPENDANTS

NAMES	DATE OF BIRTH	ALLERGY

NEAREST FAMILY /FRIEND

NAME RELATIONSHIP

ADDRESS

WORK TELEPHONE CELLPHONE

I UNDERTAKE TO PROMPTLY PAY THE ACCOUNTS RECEIVED FROM THE PRACTICE. SHOULD I FAIL TO PAY MY ACCOUNT I PAY LEGAL COSTS RELATING TO THE RECOVERY OF THE OUTSTANDING MONEY'S, IN RESPECT OF PROFESSIONAL SERVIC INCLUDING ATTORNEY/CLIENT FEES AND TRACING COSTS. I UNDERTAKE TO INFORM THE PRACTICE OF ANY CHANGE OF

SIGNITURE:



AND YOU SHALL KNOW THE TRUTH AND THE TRUTH WILL SET YOU FREE - JOHN 8:32 • PRODIGAL MINISTRIES (034-345-1110)
34 CENTRE ROAD • GOLF VIEW • WALKERVILLE • P.O. BOX 557 • WALKERVILLE • 3078