Drs HJ Botha and M Khota Inc.
B.Ch.D (Pret) / BDS (Wits)
Praktyknommer 1230565

ACC / REK NO:

PASIËNTBESONDERHEDE/ PATIENT PARTICULARS

VAN: _____ NOEMNAAM: _____
SURNAME: NAME:
VOLLE NAME: _____
FULL NAME:
GESLAG: _____ AFH KODE: _____
SEX: DEP CODE:
GEBOORTEDATUM: _____ ROOK: JA / NEE
DATE OF BIRTH: SMOKE: YES / NO
WOONADRES: _____
RESIDENTIAL ADDRESS:
SEL: _____ TEL: WERK: _____
CELL: WORK:
HUISTAAL: _____ VERWANTSKAP AAN HOOFLID: _____
HOME LANGUAGE: RELATION TO MAIN MEMBER:

REKENPLIGTIGE PERSOON / ACCOUNTABLE PERSON

MEDIESE SKEMA: _____ LID NR: _____
MEDICAL AID: MEMBER NO:
OPSIE: _____
OPTION:
HOOFLID SE NAAM & VAN: MNR/ME/DR: _____
MAIN MEMBER'S NAME & SURNAME: MR/MS/DR AFH KODE:
DEP CODE: _____
ID NR: _____ HOOFLID TEL: _____
MAIN MEMBER:
WOONADRES: _____
RESIDENTIAL ADDRESS:

E-POS ADRES: _____
EMAIL ADDRESS:

WERKGEWER: _____ TEL: _____
EMPLOYER:

FAMILIELID: _____ TEL: _____
FAMILY MEMBER:
ADRES: _____
ADDRESS:

HANDTEKENING: _____ DATUM: _____
SIGNATURE: DATE:

- SIEN AGTER -
- TURN OVER -

As 'n vergunning sal ons die rekening na U fonds stuur, maar dit bly U verantwoordelikheid om toe te sien dat dit binne dertig dae betaal word.

Rekeninge ouer as sestig dae sonder 'n aanvaarbare reëling, sal oorhandig word vir invordering.

- Ek aanvaar hiermee volle aanspreeklikheid vir die betaling van die rekening, indien my fonds dit nie vereffen nie.

As a courtesy, we will submit the account to your medical aid on your behalf, but it remains your responsibility to ensure that it is paid within thirty days.

Accounts older than sixty days without an acceptable arrangement, will be handed over for collection.

- I acknowledge that I am liable for full payment if my medical aid does not settle within thirty days.

HANDTEKENING: _____
SIGNATURE:

DATUM: _____
DATE: