DR. JS KIRSTEN ORTHOPAEDIC SURGEON

PATIENT INFORMATION

SURNAME:	**NAME**:	**TITLE**:
DATE OF BIRTH:	**ID NUMBER**:	
TELEPHONE: (**H**) (**W**)	**CELLPHONE**:	**HOME LANGUAGE**:
E-MAIL:	**FAX**:	
NAME OF MEDICAL AID:	**GAP COVER: YES / NO (Circle please)**	
MEDICAL AID NUMBER:	**OPTION**:	**DEPENDANT**:

INJURY ON DUTY

CIRCLE PLEASE: YES NO	**CONTACT PERSON**:

PERSON RESPONSIBLE FOR ACCOUNT – MAIN MEMBER OF MEDICAL AID

SURNAME:	**NAME**:	**TITLE**:
ID NUMBER:	**CELLPHONE**:	
TELEPHONE: (**H**) (**W**):	**EMAIL**:	
FULL POSTAL ADDRESS:		
HOME ADDRESS:		
EMPLOYER & WORK ADDRESS:		

OTHER INFORMATION

NAME OF GENERAL PRACTITIONER:	ADDRESS:
NAME OF REFERRING DOCTOR / PHYSIO THERAPIST:	ADDRESS:
NAME OF NEAREST FAMILY MEMBER OR FRIEND:	**RELATIONSHIP**: **TELEPHONE**:

THE PATIENT IS LIABLE FOR THE FULL PAYMENT OF THE ACCOUNT. IT REMAINS YOUR RESPONSIBILITY TO KNOW WHAT YOUR MEDICAL AID REQUIRES IN CONNECTION WITH TARIFFS, DESIGNATED SERVICE PROVIDERS, REFERRING LETTERS, PRE-AUTHORISATION, LIMITS ETC. WITH THIS YOU GIVE CONSENT FOR DISCLOSURE OF THE DIAGNOSIS CODE AND ANY OTHER MEDICAL INFORMATION CONCERNING YOUR TREATMENT AND HEALTH TO YOUR MEDICAL AID/HEALTHCARE PROVIDER/EMPLOYER.

I, the undersigned, confirm and warrant that the information as set out above is correct in every aspect. I take note that this practice follows the guidelines of the National Credit Act No. 34 of 2005. I agree that 2% interest plus an administration fee of R50.00 per month will be charged on all outstanding accounts from 30 working days. I am responsible for all recovery and legal costs (on patient/attorney scale).

The practice reserves the right to charge for any paperwork requested by the patient's medical aid or any third party insurer/company.

This practice hereby informs patients that the billing policy of the practice is not necessarily in line with the National Health Reference Price List (NHRPL) or the different rates at which the various medical insurance companies reimburse. The NHRPL is only a reference tariff list for medical services including consultations, procedures and investigations.

Patient co-payments and/or consultations are payable on the day of the consultation with cash or debit/credit card.
Patients are responsible for the full fee of a consultation not cancelled 24 hours before the consultation time.

SIGNATURE:	**DATE**:

INFORMATION SHEET

Date: _____ **Age**: _____

Which is your dominant arm? LEFT ☐ RIGHT ☐ BOTH ☐

MEDICAL HISTORY **LENGTH: _____** **WEIGHT: _____**

Do you suffer from any medical conditions?

Reply with a mark where applicable:

High blood pressure ☐ Diabetes ☐

Angina/Heart Attack ☐ Thyroid Disease ☐

Arthritis ☐ Asthma ☐

Emphysema ☐

Others: _____

Have you ever suffered from a malignant disease (e.g.cancer)? ☐

If YES, what type? _____

FAMILY HISTORY

Is there any history of arthritis in your family? ☐

If YES, which relative and what type of arthritis? _____

SURGICAL HISTORY

What operations have you had? _____

_____

DRUG HISTORY

What medication are you on? _____

_____

Are you allergic to any medication / other? _____

SOCIAL HISTORY

Do you smoke? ☐

What type of work do you do?_____

What type of sport do you play? _____

The SA Orthopaedic Registry monitors the outcome of treatment and operations in South Africa for quality control. We need your consent for further communication via e-mail/SMS in this regard.
Can we contact you?

Yes..... No..... Signature: _____