HMCD
HOWICK MEDICAL CENTRE DOCTORS

1. Patients Details

Surname	First Names	Mr/Mrs/Miss
Date of Birth	I.D. Number	
Patient contact number	Home Language	

2. Person Responsible for Account

Surname	First Name	Mr/Mrs/Miss
I.D. Number	Email	
Postal Address		Code
Home Address		Code
Employer's Name		
Occupation	Employer Address	
Tel (H)	Tel (B)	Cell

3. Medical Aid Details

Name of Medical Aid		Number
Main Member's Name		
Tel (H)	Tel (B)	Cell

4. Family/Friend (Living nearby but not with you)

Names		Relationship
Address		Code
Tel (H)	Tel (B)	Cell

5. Family Details (Dependents)

Name	Date of Birth	Allergies	Other

I certify that the information above is true and correct. I certify that I am responsible for the payment of my accounts, within 30 days of receipt. I acknowledge that all Attorney and Client Costs, Interest and Collection charges involved in the recovery thereof will be payable by me.

I understand that claims can be sent to my medical aid on my behalf, where possible. However should the medical aid not honour the claim, the responsibility of paying the account remains with me.

Full Names and Surname: _____

Signed: _____ Date:_____/_____/_____