Smiles4All

PATIENT FORM

Practice No 5438993

Tel: 012 665 1631/5
Fax: 086 605 4063
Email: smilesforall@iafrica.com

PERSON RESPONSIBLE FOR THE ACCOUNT

Personal Details

Surname ______________________ Title __________

Initials __________ Full Names ______________________

ID Number ______________________ Home Language __________

Contact Info

E-Mail Address ______________________

Contact No Cell ______________________ Home __________

Postal Address ______________________

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______________________ Code __________

Physical Address ______________________

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______________________ Code __________

Employer Details

Employer ______________________

Occupation ______________________

Contact No ______________________

Medical Aid Details

Medical Aid ______________________ Option __________

Membership Number ______________________

DETAILS OF SPOUSE

Surname ______________________ Title ______________________

Initials ______________________ Full Names ______________________

ID Number ______________________ Home Language ______________________

E-Mail Address ______________________

Contact No Cell ______________________ Home ______________________

Employer ______________________

DEPENDANTS

1 Full Names ______________________ DOB ______________________

ID No ______________________ Medical Aid ______________________

2 Full Names ______________________ DOB ______________________

ID No ______________________ Medical Aid ______________________

3 Full Names ______________________ DOB ______________________

ID No ______________________ Medical Aid ______________________

4 Full Names ______________________ DOB ______________________

ID No ______________________ Medical Aid ______________________

NEXT OF KIN

Name & Surname ______________________

Relationship ______________________ Contact No ______________________

E-Mail Address ______________________

Please take note that although we are contracted to your medical aid, payment of your account remains your responsibility should your medical aid fail to pay.

I HEREBY DECLARE THAT THE ABOVE IS TRUE AND CORRECT

______________________ ______________________

Signature Date

PLEASE READ THE FOLLOWING PARTICULARS CAREFULLY BEFORE COMPLETING THE AGREEMENT OF PAYMENT

1. This practice is registered with BHF and charges benefit scale fees. If this practice is contracted in with your medical aid, the account will be sent to your medical aid for your convenience and in terms of a special arrangement they will settle the account with us.
2. Please check your statement of account carefully for any administrative errors and rectify telephonically with the accounts department within 30 days. If the account is not adjusted within 30 days, payment remains your responsibility.
3. If this practice is not contracted in with your medical aid, the account will be sent to your medical aid for payment and you will be liable for the account in case of any short payments or non-payments.
4. In the event of a short payment or non-payment by your medical aid, you will be liable for payment of the outstanding amount.
5. It remains your responsibility to ascertain what your annual limit is with regard to consultations and other dental treatment. If this limit is exceeded you will personally be held responsible for the settlement of the outstanding amount.
6. Private patients are required to pay R750.00 before consultation, and settle the balance of the account at the end of the appointment.
7. Appointments must be cancelled 24 hours beforehand.
8. All accounts are payable 30 days after the date of service.
9. All legal and collection costs, including attorney and client costs and expenditures incurred by our practice with regard to remedy and/or recovery of the outstanding amount pursuant upon this agreement as well as any other similar costs will be for the account of the responsible person and will be payable on demand.
10. In case of bad record of payment you will be liable to pay cash in future and claim back from your medical aid.

_____________________________________ ________________________

Signature Date