medical imaging

Diagnostic Radiologists
PR No: 038 000 0008400
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PATIENT DETAILS

Title	Surname	Initials	Gender M ☐ F ☐
First Name	Relationship to Member		Dependent No.
Tel H	W	C	
I.D. No.	Patient e-mail		
Date of Birth DD / MM / YYYY	Employer		

MAIN MEMBER'S DETAILS OR PERSON RESPONSIBLE FOR PAYMENT (if different from above)

Title	Surname	Initials	First name
I.D. No.	Employer	E-mail	
Tel H	W	C	

Postal Address	Residential Address

MEDICAL AID DETAILS

Med. Aid Name	
Med. Aid No.	Med. Aid Plan

NEXT OF KIN (FAMILY/FRIEND)

Title	Surname	Initials	First name
Cell no.	E-mail		

DECLARATION:

1. I hereby declare that the information above is correct and that I accept responsibility for the account.
2. I hereby give permission that the account can be claimed directly from the medical aid. I undertake to pay all outstanding amounts not covered by the medical aid.
3. I give permission that the patient's examinations and reports be made available electronically to any physician treating the patient.

Signature: Date: