Dr. Hennie Bosch

MAIN MEMBERS DETAILS:	**ACCOUNT NUMBER:**
Surname:	First Name:
ID Number:	Title:
Postal Address:	
Code:	Home telephone and code:
Home address (if different):	
Code:	Cell phone number:
Work address:	
Code:	Work telephone and code:
Employer:	Position in firm:
E-mail address:	Spouse work telephone:

PATIENT DETAILS	
Surname:	First Name:
Date of birth / ID no:	Marriage Status:
Occupation:	Allergies:
Cell phone number:	E-mail address:
Reason for visit:	Hip / Knee /Other:_____
Height:	Weight:
REFERRED BY:	
Name:	
Name of GP:	

MEDICAL AID DETAILS	Name of option:
Name of fund:	Dependant Number:
Medical Aid Number:	
Main Member Full Name and Surname:	
GAP COVER :	YES / NO

FAMILY or FRIEND (not from same household)

Name and Surname:	
Tel and Code:	Relationship:

I confirm that the above information is true and correct. I undertake to inform you of any changes thereto within 14 days of a change occurring.

MEDICAL AID PATIENTS

I undertake to forward all accounts to the medical aid society immediately and to settle all accounts that have not been paid by the medical aid society.

PRIVATE PATIENTS

I undertake to settle the account upon receipt thereof.

Interest at 24% will be charged after 60 days.

I take note of the fact that in the event of non-payment by 90 days my name will be listed in "ITC" a national data base of slow payers.

I accept that in the event of my non-compliance with the above undertaking I will be held liable for payment of all costs incurred in collecting such moneys from me as between attorney and client, including collection commission and tracing costs

Signature:	**Date:**