DR MARK J HARRISON PRACTICE NO. 0147192
PATIENT FORM

PATIENT DETAILS

Title____Surname_____Name_____

I.D. No_____Date of Birth_____ Age_____

Postal Address_____

Residential Address _____

Occupation/Employer_____

Tel: (H)_____(W)_____(CELL)_____

FAX _____EMAIL_____

I hereby accept that emails and/or sms messages may be sent to me in order to confirm appointment and convey general information of the practice and my healthcare. Yes_____ No_____

OCCUPATION_____EMPLOYER_____

REFERRED BY _____GP_____

Would you like a report to be sent to your GP? Yes_____ No _____

NAME & TEL NO. OF A FAMILY MEMBER/FRIEND (For Acc purposes should we be unable to contact you)

_____

MAIN MEMBER OF MEDICAL SCHEME (Please note that all adults are responsible for their own accounts, even if they are dependants on someone else's scheme)

Title_____Surname_____Name_____

I.D. No_____Date of Birth_____Age_____

Postal Address_____

Residential Address_____

Occupation/Employer_____

Tel: (H)_____(W)_____(CELL)_____

FAX _____EMAIL_____

MEDICAL SCHEME_____**PLAN/OPTION**_____

MEDICAL AID NUMBER_____**GAP COVER?**_____

Terms and Conditions of the Practice

By signing this form you acknowledge that you have understood the agreed to the following:-
To always ask, if you were uncertain about something. You can ask practice staff or the doctor. If you keep quiet, practice staff and the doctor will assume that you have understood everything and were in agreement with any processes, consent, policies or forms. If you do not keep your appointment (for any reason whatsoever, apart from emergencies) and you have not let us know at least 24 hours before the appointment, we reserve the right to charge a cancellation fee, as we have kept the slot open for you and could not assist another patient.

_____ _____ _____

SIGNATURE **DATE** **WITNESS**