dr petrie vd merwe
MAXILLO-FACIAL & ORAL SURGEON

021 300 1572 | admin@drpetrievdmerwe.co.za
www.drpetrievdmerwe.co.za
44 Reitz Street, Somerset West, 7129

BChD (UWC), MBChB (UP), PDD (Oral Surgery) (UWC), MChD (Chir.Max-Fac.Med)(UP)
HPCSA Nr. DP0099856 | Practice Nr. 1140418

REFERRING PRACTITIONER DETAILS			
REFERRING PRACTITIONER NAME:			
1. PATIENT INFORMATION			
SURNAME:	FULL NAMES:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Prof. ❑ Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
MOBILE ☎:	OCCUPATION:		
E-MAIL ADDRESS:	DEPENDENT CODE E.G. 00, 01 (If claim is to be sent to the medical aid):		
Correspondence for Administrative (appointments, accounts, etc.) and General Practice purposes: ☐ I accept ☐ I decline	Correspondence for Promotional and Educational Information regarding my healthcare: ☐ I accept ☐ I decline		
2. MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT / MEDICAL AID DETAILS (please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)			
SURNAME:	FULL NAMES:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Prof. ❑ Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
RELATIONSHIP TO PATIENT:			
PHYSICAL ADDRESS:	MOBILE ☎:		
	E-MAIL ADDRESS:		
MEDICAL AID:	MEDICAL AID PLAN:	MEDICAL AID #:	
FAMILY / FRIEND CONTACT DETAILS: *(for account purposes should we be unable to contact you)* **NAME:**_____	☎_____	✉_____	
OCCUPATION:	EMPLOYER NAME:		
EMPLOYER CONTACT DETAILS: *(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)*	☎_____	✉_____	

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3. MEDICAL HISTORY

ALLERGIES: (please list below if applicable)	CHRONIC MEDICATION: (please list below if applicable)

INDICATE WHERE APPLICABLE:

- ☐ Asthma
- ☐ Bleeding condition
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Human Immunodeficiency Virus
- ☐ Hypertension
- ☐ Immune mediated conditions
- ☐ Liver conditions
- ☐ Porphyria
- ☐ Pregnant
- ☐ Psychological conditions
- ☐ Respiratory conditions
- ☐ Smoking

TERMS & CONDITIONS OF THE PRACTICE

I, the undersigned, confirm that:

1. I hereby consent thereto that Dr Petrie vd Merwe (and / or duly appointed, qualified and registered representative) to examine myself, family member or legal dependent (unable to consent for themselves). I consent that, after discussion and careful consideration of the risks and benefits of surgery, that Dr Petrie vd Merwe perform surgery on myself, family member or legal dependent
2. That I have the consent of a family member/friend and my employer to disclose their contact details
3. Where I, the patient, am not the Main Member, I have the consent of the Main Member to disclose his/her details for account administration
4. That the patient (dependent) or main member is primarily responsible for payments of accounts for services rendered
5. Medical schemes differ regarding benefits for services rendered, and that it is the responsibility of the patient or main member to contact the medical scheme prior to appointment/admission to confirm any specific stipulations
6. I also accept liability for professional fees that may result from consultation, consumables, and treatment
7. I acknowledge that authorisation from my medical scheme is not a payment guarantee and accounts need to be settled within 30-days of service rendering
8. Should any legal action be required to recover outstanding fees, the legal fees at attorney-client scale will be for my account
9. Interest will be charged on accounts that are in arrears for 30-days or more. Interest rates on outstanding accounts are based on HPCSA regulations
10. Appointments must be cancelled within 24 hours and failing to do so will result in the full consultation fee being charged
11. The accompanying **"Patient Information Document" (provided to you separately)** has been read and that you as the patient is bound to the content thereof and that you have had an opportunity to ask questions on aspects thereof that you were not certain about
12. You are aware of your rights under the POPI Act, including your right to refuse to consent to marketing and to refuse disclosures - unless required by a law, and to change or remove information, where possible
13. The Account Holder, surety or legal guardian hereby consents to the disclosure and exchange of personal financial information to a credit bureau or financial institution in accordance with the National Credit Act

Information about you cannot be exchanged without your consent. Your signature on this release authorises This Practice to obtain and release personal information regarding your care in accordance with PAIA and POPIA Compliance.
Personal & Special Personal Information is collected, stored & shared by This Practice for the following reasons (for a more comprehensive description of all records held at The Practice as well as policies implemented by The Practice, please contact The Practice Information Officer for a copy of the PAIA Manual as well as the POPIA Compliance Manual.

PURPOSE: For the holistic treatment of you as the patient; For the administration of your patient treatment and the practice; For the performance of duties in terms of any agreement between yourself and the practice; Administrate your accounts and manage any application, agreement, or correspondence that you may have with The Practice; Any other reasonably required purpose relating to The Practice.

Please note, that this practice is administrated by **MFI** (operator) and as a result, the following information is disclosed for administrative purposes: *Client/patient contact and medical aid details, ICD-10 codes, correspondence and Consultation dates and procedures.*

☐ ***I accept this authorization***

☐ ***I do not accept this authorization*** *in the event you choose to keep all information confidential, please note that the payment for all services rendered will be payable on date of service, as the administration process cannot continue)*

1._____ _____ **2.**_____ _____
Patient Name **Signature** **Person Responsible for Account (Main member/patient)** **Signature**

Signed at: _____ _____/_____/**20**_____