vdm optometrists

BESONDERHEDE VAN PASIËNT

TITEL:_____ VOORNAME EN VAN: _____AFHANKLIKE KODE _____

GEBOORTEDATUM:_____/_____/_____ I.D NOMMER: _____

BEROEP: _____

TEL NOMMERS (HUIS): _____ (WERK): _____

(SELFOON):_____ E-POS:_____

BESONDERHEDE VAN MEDIESE FONDS

SKEMA: _____ NOMMER: _____

OPSIE: _____

BESONDERHEDE VAN PERSOON VERANTWOORDELIK VIR DIE REKENING (HOOFLID)

TITEL:_____

VOORNAME EN VAN: _____

GEBOORTEDATUM: _____/_____/_____ I.D NOMMER: _____

HUISADRES: _____

POSADRES:_____

BEROEP: _____

WERKGEWER: _____

TEL NOMMERS (HUIS): _____ (WERK): _____

(SELFOON):_____ E-POS:_____

WIE KAN ONS BEDANK VIR U VERWYSING NA ONS PRAKTYK?

NAAM EN VAN: _____

SELFOON: _____

BYDRAES DEUR U MEDIESE FONDS:

- Vir u gerief sal ons (indien deur u verlang) u rekening by u ingekontrakteerde fonds indien vir direkte betaling aan ons.
- **Mediese fondse dra slegs 'n gedeelte van die rekening by en nie noodwendig die volle bedrag nie.**
- Alhoewel alle moontlike pogings aangewend word om die korrekte bydrae deur u fonds vas te stel, is dit steeds net 'n beraamde waarde en word nie gewaarborg nie. Met die berekening van u persoonlike bydrae tot die rekening, gebruik ons hierdie beraamde bedrag wat moontlik mag verander.
- **Enige bedrag nie deur u fonds vereffen nie, bly u verantwoordelikheid**.

Ek, _____, die ondergetekende, bevestig hiermee dat ek die bogenoemde gelees het en dat ek die inhoud ten volle verstaan en aanvaar.

Handtekening: _____Datum: _____

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DETAILS OF PATIENT:

TITLE:_____ NAME AND SURNAME: _____

DATE OF BIRTH: _____/_____/_____ I.D NUMBER: _____

DEPENDANT CODE _____ OCCUPATION: _____

TEL NUMBERS (HOME): _____ (WORK):_____

(CELL): _____ E-MAIL: _____

MEDICAL AID DETAILS:

SCHEME: _____ NUMBER: _____

OPTION: _____

DETAILS OF PERSON ACCOUNTABLE (MAIN MEMBER)

TITLE:_____

NAME AND SURNAME: _____

DATE OF BIRTH: _____/_____/_____ I.D NUMBER: _____

HOME ADDRESS: _____

POSTAL ADDRESS: _____

OCCUPATION: _____

EMPLOYER: _____

TEL NUMBERS (HOME): _____ (WORK):_____

(CELL): _____ E-MAIL: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

NAME AND SURNAME: _____

CELLPHONE: _____

CONTRIBUTIONS BY YOUR MEDICAL AID:

- For your convenience we will (if so required by you) submit your account to your medical aid for direct payment - if we are contracted to them.
- Medical aids only contribute a portion of your account and not necessarily pay the full amount.
- Although every effort is made to confirm the correct amount contributed by the medical aid, it is merely an estimate and can therefore change. In calculating the estimated patient portion of the account, we use an estimated medical aid contribution which may vary.
- Any amount not paid by your medical aid is payable by you.

I, _____, the undersigned, agree to the conditions above and have read and understand the terms and content thereof.

Signature: _____ Date: _____