Dr Dagmar Whitaker

SEG (Frankfurt); MD (Frankfurt); M.MED. DERM (Stell)

Dermatologist * Dermatoloog

PR. No 1201530

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*Even though we are a **Private Practice**, should you want to claim back from your Medical, please supply this information and it will be printed on your statement :*

Medical Aid : Yes ☐ No ☐ **Medical Aid Name** _____

Membership No _____

Referred to Dr Whitaker by (If applicable) _____

MAIN MEMBER'S DETAILS

Title : _____ Initials : _____ Full Names : _____

Surname : _____ Occupation _____ Employer _____

I.D Number : _____ DOB ____/____/_____ Male ☐ / Female ☐

Home No : _____ Work No : _____

Mobile No : _____ Email Address : _____

PATIENT'S INFORMATION (If same as Main Member not necessary to repeat information) :

Title : _____ Initials : _____ Full Names : _____

Surname : _____ Occupation _____ Employer _____

I.D Number : _____ DOB ____/____/_____ Male ☐ / Female ☐

Home No : _____ Work No : _____

Mobile No : _____ Email Address : _____

(If your Child is the patient – please put Parent's mobile number and email address here) _____

PHYISCAL ADDRESS DETAILS (House / Unit Number, Estate Name, Street Name and Suburb)

_____

_____ Postal Code : _____

I hereby acknowledge that I will be personally responsible to settle my account on the day of consultation, otherwise I will be held liable for interest that may accumulate and legal charges that may arise. I am fully aware that Dr Whitaker runs a private practice and does not liaise with any medical aids and that as a patient I must liaise with my own Medical Aid regarding funds, submission of accounts and other enquiries.

Signature : _____ Date : _____