DR DAGMAR WHITAKER
DERMATOLOGIST

ACCOUNT NR: ______________

INITIAL CONSULTATION: **KENILWORTH ☐ / VINCENT PALOTTI ☐**

MEDICAL AID: YES ☐ NO ☐

MEDICAL AID NAME: ______________________________ **MEMBERSHIP NR:** ______________________

HOW DID YOU HEAR OR GET TO KNOW ABOUT DR WHITAKER? INTERNET / PHONEBOOK / FRIEND OR RELATIVE / REFERRED BY ANOTHER DOCTOR

REFERRED BY: .... (IF APPLICABLE)

MAIN MEMBER INFORMATION:

(TO BE COMPLETED WHEN CLAIMING FROM MEDICAL AID)

TITLE:______________ **INITIALS:**___________ **FULL NAMES:**____

SURNAME:________________________ **OCCUPATION:**_________________________ **DOB:**____/______/_____

ID NR:______________________________ **EMPLOYER:**_________________________ **MALE ☐ FEMALE ☐**

PATIENT INFORMATION:

TITLE:______________ **INITIALS:**___________ **FULL NAMES:**____

SURNAME:________________________ **OCCUPATION:**_________________________ **DOB:**____/______/_____

ID NR:______________________________ **EMPLOYER:**_________________________ **MALE ☐ FEMALE ☐**

POSTAL ADDRESS: ____ **TEL (H): (___)** ____________________

____ **TEL (W): (___)** ___________________

____ **CELL:** __________________________

_________________________**POSTAL CODE:** ________ **EMAIL:** _____________________________________

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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 do not liaise with any medical aids and that as a patient I must liaise with my own medical aid regarding refunds, submission of accounts and other enquiries. If I do decide to make direct deposits / electronic transfers as payment, I will ensure that I fax through PROOF OF PAYMENT.

SIGNATURE: _______________________________ **DATE:** _________________________