You are required to fill out this patient information form for every visit. We also need copies of your ID and your medical aid membership card.

Diagnostic Radiological Services Inc.
PR. 3800466

Patient Information Form

PATIENT DETAILS (Please print clearly)

Title:_____ Initials:_____ ID No.:_____

First names:_____ Surname:_____

Date of birth:_____ Relationship to member.:_____

Dependant no.:_____

Email address:_____

Tel. no.(H):_____ (W):_____

Cell no.:_____ SAP Force no.:_____
If applicable

MAIN MEMBER INFORMATION (PERSON RESPONSIBLE FOR ACCOUNT)

Title:_____ Initials:_____ ID No.:_____

First names:_____ Surname:_____

Medical aid name:_____

Medical aid Option/Plan:_____ Medical aid no.:_____

Email address:_____

Postal address:_____

_____ Code:_____

Street address:_____

_____

Employer name:_____

Employer address:_____

Tel. no.(H):_____ (W):_____

Cell no.:_____

CONTACT DETAILS OF PERSON NOT STAYING AT SAME ADDRESS

Tel. No.:_____ Relationship:_____

First name:_____ Surname:_____

Address:_____

_____

Referring Doctor:_____

I hereby accept full responsibility for the account and acknowledge that I have read and accept the terms and conditions as printed on the reverse side of this document.

*Full name:*_____

*Signature:*_____ *Date:*_____

OFFICE USE
TIME IN

Diagnostic Radiological Services Inc.
Practice Number: 3800466

TERMS AND CONDITIONS

I, the undersigned hereby declare and warrant that:

- The information provided below is true and correct.
- I undertake to settle the account of Diagnostic Radiological Services Inc. immediately should my Medical Aid refuse to settle my account for whatever reason.
- I agree to pay all and/or any costs, fees and or disbursement incurred by Diagnostic Radiological Services Inc. for the collection of amounts owing by me which may include tracing costs, debt collectors fees and commission as well as attorney fees and disbursements on the scale of attorney and own client.
- I grant consent for any injection and/or other administration of any drugs and/or contrast media which may be deemed necessary for the performance of any medical imaging examination.
- In the event that I am hospitalised, I hereby grant consent for all medical imaging and adminitration of any drugs and contrast media that may be deemed necessary during my stay in hospital.
- I hereby authorise Diagnostic Radiological Services Inc. who are in possession of information concerning my medical diagnosis and treatment, together with my health and personal particulars to disclose such information to my healthcare funder and other healthcare providers. Permission to disclose such information is only for the purpose of treatment and management of my medical condition. I wish to indicate that this consent is given out of my own free will without any undue influence whatsoever.
- By signing this document, I confirm that I am aware that the practice may make the X-rays and other digital images taken by the practice, available in a digital electronic form to medical practitioners, involved in the treatment and management of my medical condition.
- By signing this document, I confirm that I shall be deemed to have read and understood the terms and conditions contained herein and that I am legally bound thereby.

_____ _____

Signature Date