



MAXILLO FACIAL & ORAL SURGEON

DR NAEEM MAHOMED

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I would like to welcome you to my practice. In order for us to provide you with the best care please provide the following details:

PATIENT DETAILS:

Surname: _____ Title: _____

Name: _____ I.D. No/Date of Birth: _____

Physical Address: _____

_____ Code: _____

Postal Address: _____

_____ Code: _____

Tel: Home: _____ Work: _____ Mobile: _____

E-mail: _____

Medical Aid: _____ Plan: _____

Medical Aid No: _____

Gap Cover [Y/N]: If Yes, name of provider: _____

Full Name of Main Member: _____

Main Member I. D. No: _____ Dependant number: _____

Next of Kin: _____ Relationship: _____

Tel: _____

Referring Dr: _____ Tel: _____

PLEASE NOTE: THIS IS A PRIVATE PRACTICE, AND OUR FEES MAY EXCEED YOUR INSURED BENEFITS. PLEASE SETTLE YOUR FULL ACCOUNT ON RECEIPT THEREOF AND CLAIM BACK FROM YOUR MEDICAL INSURER.

PLEASE NOTE, MEDICAL AID IS ONLY AN AID TO COVERING YOUR MEDICAL EXPENSES AND MAY NOT COVER YOUR FULL BILL. PLEASE CONFIRM BENEFITS WITH YOUR MEDICAL AID PROVIDER PRIOR TO ACCEPTING ANY PROPOSED TREATMENT.

I hereby accept full responsibility for the settlement of this account as rendered by Dr Mahomed. I agree to pay all costs that may be incurred in the event of my failure to settle any amounts as per above agreement. I have read and fully understand the terms of the above statement.

Full Name: _____

Signature: _____ Date: _____