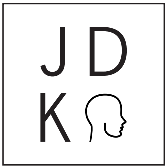

DR. JOHANN D. KLUGE

MBCHB . MMED (ENT) | PRACTICE NUMBER: 0530077

TELEPHONE: 012 346 0879 / 3664

FAX: 086 603 5556

Life Groenkloof Hospital, Suite 110, 50 George Storrar Drive, Groenkloof, Pretoria, 0181

MAIN MEMBER INFORMATION:

ID Number: ____________ *Surname: ____________

*Full Names: ____________ Initials: ________ Title: ________

Home Language: ____________ Gender: ☐ MALE ☐ FEMALE

*Cell Number: ____________ *Date of Birth: C C Y Y / M M / D D

Work Number: ____________ Home Number: ____________

Fax Number: ____________ Employer: ____________

Email Address: ____________ Email Statements: ☐ YES ☐ NO

*Postal Address: ____________

*Postal Code: ____________

Physical Address: ____________

Postal Code: ____________

*Medical Scheme: ____________ *Plan/Option: ____________

*Member Number: ____________ Gap Cover: ☐ YES ☐ NO *M/M Dep Code: O O

PATIENT INFORMATION:

ID Number: ____________ *Surname: ____________

*Full Names: ____________ Initials: ______ Title: ______ Marital Status: ______

Home Language: ____________ *Date of Birth: C C Y Y / M M / D D

*Cell Number: ____________ Use this number for appointments/test results ☐ YES ☐ NO

Home Number: ____________ Main member's cellphone number will be used if the above is "No".

Work Number: ____________ Gender: ☐ MALE ☐ FEMALE

Occupation: ____________ Email Address: ____________

*Relationship to Main Member: ____________ *Patient Dep Code: O O

Height: ________ meter Weight: ________ kilogram Age: ________ years

Referring Doctor: ____________ Telephone Number: ____________

NEXT OF KIN: (not from same physical address)

Full Names: ____________ Surname: ____________

Cell Number: ____________ Initials: ________ Title: ________

Relationship to Patient: ____________

Hereby I confirm that the information I supplied is true and I am responsible for any false information provided.

*Name in Print: ____________

*Date of Signature: C C Y Y / M M / D D *Signature: ____________

Allow mass communication or notices from practice ☐ YES ☐ NO

All fields with * are mandatory. Please note that you (or your parent/guardian) remain liable for the account for services rendered by this practice, even if you are insured by a medical aid or other third party. Please ensure that you have read and signed the attached Doctor-Patient contract.