Dr Jan Kleynhans Plastic Surgeon

M B Ch B M Med Incorporated Reg No: 98/ 0892321

PATIENT REGISTRATION FORM (Please print) **Account Number .....**

PATIENT'S PARTICULARS:

SURNAME: _____FIRST NAMES:___ _____DATE OF BIRTH: _____

MARITAL STATUS: (Please tick) Single:_____ Married_____ Widow/er: _____ Divorced: _____

IDENTITY NUMBER: _____

OCCUPATION: _____ CELL NO: _____

TEL NO: Home: _____Work: _____ Fax: _____ Email: _____

HOME ADDRESS: _____Post Code: _____

POSTAL ADDRESS: _____Post Code: _____

PERSON RESPONSIBLE FOR ACCOUNT: (If other than the patient)

SURNAME: _____FIRST NAMES: _____ RELATIONSHIP _____

IDENTITY NUMBER: _____

OCCUPATION: _____

TEL NO: Home: _____ Work: _____ Fax: _____ Email: _____

HOME ADDRESS: _____Post Code: _____

POSTAL ADDRESS: _____Post Code: _____

EMPLOYER: _____EMPLOYER'S PHONE NO: _____

NAME OF FRIEND/RELATIVE: _____RELATIONSHIP_____TEL NO: _____

MEDICAL AID: _____NUMBER: _____OPTION_____

"TOP UP" INSURANCE: _____

REFERRING DOCTOR: _____USUAL FAMILY DOCTOR: _____

DOCTOR'S FEES:

This practice charges fees as recommended by the Health Professionals Council of South Africa. Our fees are higher than "Medical Aid Rates" **Patients are personally responsible for the payments of their accounts.** A receipted account will be issued to submit to your medical aid for claim purposes.

ACCEPTANCE OF TERMS:

I certify that the above particulars are correct and agree to notify you immediately of any changes of personal particulars. Medical aid, address, etc. I agree that I am responsible for payment of my account immediately when rendered. Interest may be charged on overdue accounts at current bank rates.
I hereby undertake to pay all attorney/client costs, including collection fees and interest incurred, if handed over for collection. I consent to the jurisdiction of the Magistrate's Court having jurisdiction in terms of Act 32.a 944 as amended.

If the parents of underage patients are separated the person who signs this form will be undertaking to pay the account in full unless written guarantee of payment is received from the legal guardian.

PATIENT'S SIGNATURE: _____PARENT'S SIGNATURE: (If minor) _____

DATE: _____

HEALTH QUESTIONAIRE

MEDICAL HISTORY: (Please tick relevant answers)

Are you in good health at the moment? YES__ NO__

HAVE YOU HAD ANY OF THE FOLLOWING? IF "YES" please describe

HEART DISEASE YES__ NO__
……
RHEUMATIC FEVER YES__ NO__
……
BLOOD PRESSURE : HIGH… LOW… YES__ NO__
……
ANAEMIA YES__ NO__
……
BLOOD CLOTTING PROBLEMS YES__ NO__
……
DEEP VENOUS THROMBOSIS YES__ NO__
……
DO YOU BRUISE EASILY YES__ NO__
……
DIABETES YES__ NO__
……
HEPATITUS (JAUNDICE) YES__ NO__
……
LIVER OR KIDNEY DISORDERS YES__ NO__
……
GASTRIC/INTESTINAL ULCERS YES__ NO__
……
EPILEPSY YES__ NO__
……
ASTHMA OR LUNG DISORDERS YES__ NO__
……
TREATMENT FOR HIV/AIDS YES__ NO__
……
RECENT WEIGHT LOSS/GAIN YES__ NO__
……
PREGNANT AT PRESENT YES__ NO__...
……
DO YOU FORM BAD SCARS /KELOIDS YES__ NO__
……
ARE YOU A POOR/SLOW HEALER YES__ NO__
……
PREVIOUS OPERATIONS YES__ NO__
……
DO YOU SMOKE YES__ NO__
……
ANTI-DEPRESSANT MEDICINES YES__ NO__
……
CORTISONE/STEROID MEDICINES YES__ NO__
……
ARE YOU TAKING ANY OTHER MEDICINES? YES__ NO__

WHICH MEDICATIONS: ……

……

ANY ALLERGIES? YES__ NO___……

CURRENT HEIGHT: …… CURRENT WEIGHT:……

ANY OTHER FACTS THAT THE DOCTOR SHOULD KNOW ABOUT ?
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