ERASMUS
CHIROPRACTIC

PATIENT'S DETAILS			
Surname		Initials	
Full names			
ID number / Date of Birth		Gender ☐ Male ☐ Female	Age
MAIN MEMBER OF MEDICAL AID or PERSON RESPONSIBLE FOR ACCOUNT			
Surname		Initials	
Full names			Relationship to patient
Title ☐Mr ☐Mrs ☐Miss ☐Dr	ID Number		
Home phone number	Work phone number	Fax number	
E-mail address			
Home address Code			
Postal address Code			
Occupation			
Employer			
Parent Details	Name	Cell Number	Email
Address			
MEDICAL AID DETAILS			
Medical Aid		Plan / Option	
Medical Aid Number		Dependant Number	
IN CASE OF EMERGENCY			
Name of local friend or relative (not living in the same address):			
Home address:		Relationship to patient	
Home number:		Cell number	

THE PATIENT IS LIABLE FOR THE FULL PAYMENT OF THE ACCOUNT. IT REMAINS YOUR RESPONSIBILITY TO KNOW WHAT YOUR MEDICAL AID REQUIRES IN CONNECTION WITH TARIFFS, DESIGNATED SERVICE PROVIDERS, REFERRING LETTERS, PRE-AUTHORISATION, LIMITS ETC. WITH THIS YOU GIVE CONSENT FOR DISCLOSURE OF THE DIAGNOSIS CODE AND ANY OTHER MEDICAL INFORMATION CONCERNING YOUR TREATMENT AND HEALTH TO YOUR MEDICAL AID/HEALTHCARE PROVIDER/EMPLOYER.

I _____ hereby declare that the information I have provided is true and correct and agree to the terms and conditions as set out above.

Patient Signature _____ **Date of Signature** _____