DR. ASHNEE GOVENDER INC.
SPECIALIST PHYSICIAN
BSc, BSc(Med)(Hons), MBChB(UCT), FCP(SA), MMed(Stell)

Suite 1002, Ground Floor,
Vincent Palloti Hospital
Alexandra Road, Pinelands
Cape Town, 7405

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PATIENT DETAILS							
Full Name and Surname:							
Title: (tick next to)	**Mr**	**Mrs**	**Miss**	**Ms**	**Dr**	**Prof**	**Rev**
ID Number:							
Occupation:							
Spouse/Partner's Name:							
Spouse/Partner's ID Number:							
Emergency Contact Person:							
Contact Number:							

RESIDENTIAL AND CONTACT DETAILS	
Home Postal Address:	
Work Address:	
Tel (H):	**Tel (W):**
Cellphone:	
Email:	

GENERAL PRACTIONER
GP Name:
GP Contact Number:
Referred By:
Contact Number:

MEDICAL AID AND ACCOUNT RESPONSIBILITY
Medical Aid:
Plan and Option:
Membership/Medical Aid Number:
Gap Cover:
Main Member Name and Surname:
Main Member ID Number:
Patient Dependant Code:
Person Responsible For The Account:

NEXT OF KIN
Name and Surname:
Relationship To Patient:
Address:
Contact Number:
Email:

FRIEND/RELATIVE AT A DIFFERENT ADDRESS
Name and Surname:
Relationship To Patient:
Address:
Contact Number:
Email:

DECLARATION

I, the undersigned, am personally responsible for payment and not my medical aid. In the event of divorce the parent accompanying the minor must settle the account. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. In the event that my account is handed over there will be no further correspondence entered into with the practice which includes follow up appointments, prescriptions or additional document requests. All correspondence will be handled directly with the credit bureau.

I have read, understood and agree to the conditions mentioned in the above declaration and in the Practice Protocol Notification of Dr Ashnee Govender Incorporated. I confirm that the information provided by me is true and correct and if any information should change, I will inform the practice of these changes.

SIGNED: _____ WITNESS: _____

DATE: _____