DR R O A RAMMUTLA

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PATIENT DETAILS:

SURNAME: _____ **FULL NAME:** _____
I.D. NO: _____ **HOME NUMBER:** _____
CELL NUMBER: _____ **EMAIL ADDRESS:** _____
RESIDENTIAL ADDRESS: _____
_____ **CODE:** _____
MEDICAL AID: _____ **PLAN:** _____
MEDICAL AID NUMBER: _____ **DEP CODE:** _____
OCCUPATION: _____ **COMPANY NAME:** _____
WORK ADRESS: _____ **CODE:** _____
WORK TEL NO: _____
REFERING DOCTOR: _____

PERSON RESPONSIBLE FOR ACCOUNT:

SURNAME: _____
FULL NAME: _____
I.D. NO: _____
CELL NUMBER: _____
HOME NUMBER: _____ **EMAIL ADDRESS:** _____
RESIDENTIAL ADDRESS: _____
_____ **CODE:** _____
MEDICAL AID: _____ **PLAN:** _____
MEDICAL AID NUMBER: _____ **DEP CODE:** _____
OCCUPATION: _____ **COMPANY NAME:** _____
WORK ADRESS: _____ **CODE:** _____
WORK TEL NO: _____
REFERING DOCTOR: _____

NEXT OF KIN:

NAME AND SURNAME: _____
RESIDENTIAL ADRESS: _____ **CODE:** _____
CONTACT NUMBER: _____

PLEASE NOTE THAT IF PAYMENT IS NOT MADE WITHIN 60 DAYS, ACCOUNT WILL BE HANDED OVER TO OUR ATTORNEYS FOR COLLECTION. YOU WILL BE LIABLE TO PAY ANY/ ALL COLLECTION AND/OR ATTORNEY CLIENT SCALE FEE.

SIGNATURE: _____ **DATE:** _____