Dr M.R. Kalan and Associates
B.Sc., B.Ch.D., M.Ch.D., P.D.D.

1st Floor, 18 Main Road
Rondebosch

Personal Details *(Complete in block letter*

Date: *(dd/mm/yy)*

Surname: First Name

ID Number: D.O.B: *(dd/mm/yyyy)*

Cell No: Age: Title: Dr/ Mr/ Mrs/ Ms/ Miss/ Master

Are you a Full Time Student? Y / N Year of Completion of Studies:

LOCAL ADDRESS/CAMPUS ADDRESS:	**POSTAL/PERMANENT ADDRESS** *(if different from local address)*
Postal Code:	Postal Code:
Tel. Home:	Tel. Work:
E-mail:	Fax:
Occupation:	Employer:

Medical Aid Benefits

Main Member:	Medical Aid Name:
Main Member's ID:	Medical Aid No.:
Dependant Code:	

Medical History *(Please answer all question*

Name of Medical Doctor: Contact No.:

Ever been treated for heart disease, diabetes, epilepsy, rheumatic fever, TB, liver or digestive diseases?

If YES, please specify: Y / N

Any prolonged bleeding or blood disorders?

Allergic to any medication? Please list.

Any other illnesses? Please specify: Y / N

If relevant, are you pregnant? Y / N

Please note:

The private fees charged at this practice are higher then the scale of benefits of the Medical Aid Societies . In the event of the account being in arrears, the amount owing draws interest at the rate of 20% per annum. In addition postage and administration fees will be charged for reminders on outstanding amounts. The patient/member/guardian is ultimately responsible for payment of the outstanding account that is due for services rendered at this practice. I,.. hereby state that I understand the contents of this page and that the information supplied is correct. Signature:

BENEFITS CONFIRMATION:

DATE					
AMOUNT					
B/WINGS					
S&P					
FILLINGS					
FL					
PAN					
OTHER					