GoHealth
Family & Travel Medicine Practice

Dr. Venter & Partners
PR 0140000263613

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PATIENT REGISTRATION FORM

Person Responsible for Account			
Surname:			
Full Name:			
ID Number:			
Contact Details:	Mobile	Work	Email
Postal Address:			

Medical Aid Information	Next of Kin
Medical Aid:	Surname:
Option / Plan:	Full Name:
Medical Aid Number:	Contact Numbers: Mobile
Main Member:	Additional Mobile

Patients			
Surname:		Surname:	
Full Name:	1	Full Name:	2
ID Number:		ID Number:	
Contact Numbers:		Contact Numbers:	
Dependent Code:		Dependent Code:	
Surname:		Surname:	
Full Name:	3	Full Name:	4
ID Number:		ID Number:	
Contact Numbers:		Contact Numbers:	
Dependent Code:		Dependent Code:	

I, _____ hereby declare that I have provided true and correct information. I understand that Go Health Family and Travel Medicine Practice / Dr Venter & Partners is a private practice and that all fees charged are my responsibility should my medical aid not settle the claim within 90 days from the date of service.

I also agree to settle my account within 30 days, should the account not be claimable from my medical aid. I agree to settle my account immediately should I be a private patient.

I understand that Go Health Family and Travel Medicine Practice / Dr Venter & Partners has the right to hand over my account for any amount in arrears after 90 days from date of service.

_____ _____ _____

Name in Print Signature Date

Partners:
Dr. S. Serfontein MBChB(Pret) MFamMed(Pret) **Dr. A. J. Venter** MBChB(UFS) **Dr. B. M. Gouws** MBChB(Pret) DipPEC(SA) **Dr. S. Kotzé** MBChB(Pret)
Go Health at Lifestyle 2013/232969/07