TheraMed NUCLEAR

PR 1230727

BA Young and GH Bennie
Nuclear Medicine Inc
Registration number: 2015/03842/21

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PATIENT INFORMATION

TIME hh:mm

DATE dd/mm/yyyy

PATIENT INFORMATION

TITLE | INITIALS | DEP. CODE. | REL. TO MEMBER | FIRST NAMES

SURNAME | LANGUAGE | GENDER --Select-- | I.D. NUMBER

DATE OF BIRTH dd/mm/yyyy | EMPLOYER

HOME ☎ | WORK ☎ | FAX

CELL ☎ | E-MAIL ADDRESS

PREVIOUS OPERATIONS OR CONTRAST EXAMINATION?

ALLERGIES? YES NO PLEASE SPECIFY

REF. DOCTOR | AUTH. NO.

SMOKING? --Select-- | ARE YOU PREGNANT? --Select-- | ASTHMA? --Select-- | ARE YOU BREASTFEEDING? --Select--

HIGH BLOOD PRESSURE? --Select-- | KIDNEY FAILURE? --Select--

PERSON RESPONSIBLE FOR PAYMENT

TITLE | INITIALS | DEP. CODE | REL. TO PATIENT | FIRST NAMES

SURNAME | LANGUAGE | GENDER --Select-- | I.D. NUMBER

DATE OF BIRTH dd/mm/yyyy | EMPLOYER

HOME ☎ | WORK ☎ | FAX

CELL ☎ | E-MAIL ADDRESS

POSTAL ADDRESS

RESIDENTIAL ADDRESS

MED. AID NAME | MED. AID NO.

B.A.D. | DATE OF INJURY dd/mm/yyyy | CLAIM NUMBER | EMPLOYEE NO.

EMPLOYERS ADDRESS

RELATIVE OR FRIEND

NAME

HOME ☎

CELL ☎

DECLARATION

PLEASE NOTE: NOT RESPONSIBLE FOR LOSS OF VALUABLES

NB.: ALL PATIENTS WILL BE HELD RESPONSIBLE FOR ACCOUNT UNTIL SETTLED

Constitutional requirements necessitate that all patients acknowledge our term of service.

I, _____ the undersigned do hereby agree that:

I have **been informed about the procedure**, understand its nature, and have had a chance to **ask questions**.

- I am **aware of the possible complications and risks** associated with the procedure.
- **I authorise and consent** to the performance of this procedure.
- **I give consent to the injection of any necessary drug or contrast media** required for the examination.
- I understand that **sedation may cause negative effects and loss of concentration** and will **not drive or operate machinery for at least 8 hours** after sedation.
- I **accept personal responsibility for the payment** of the account to the practice, even if pre-authorization was granted by my medical aid. Pre-authorization does not guarantee payment.
- I undertake to be **liable for all legal costs/fees** necessary for the recovery of payment and accept the responsibility for payment and interest in collecting outstanding fees as laid down by the Health Professions Council of South Africa (HPCSA).
- (*If applicable*) I declare that I am the **legal guardian/custodian** of the above-named child and understand and accept this contract on their behalf.

Signature: _____ Date: dd/mm/yyyy Place: _____

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