DR ANDRE BURGER
Ophthalmologist
MBChB (SA), FCOPHTH (SA), DIPOPHTH (SA), DIPPEC (SA)
Fellowships - OCULOPLASTICS (UK), VITREO-RETINAL (UK)
Practice No: 026 000 0465399 | MP: 0539783

ACCOUNT NO: _____

PATIENT DETAILS:

SURNAME: _____ FIRST NAMES: _____

TITLE: _____ DATE OF BIRTH: _____ AGE: _____ ID NO: _____

DEPENDANT NO: _____ (AS STATED ON MEDICAL AID CARD)

PERSON RESPONSIBLE FOR ACCOUNT (M/AID HOLER):

SURNAME: _____ INITIALS:_____FIRST NAMES:_____

TITLE: _____ MARITAL STATUS: _____ ID NUMBER: _____

POSTAL ADDRESS: **RESIDENTIAL ADDRESS**

_____ _____

_____ _____

_____ _____

_____ CODE _____ _____ CODE: _____

TEL NO (H): _____ CELL: _____ EMAIL_____

EMPLOYERS NAME: _____ TEL NO(W): _____

MEDICAL AID DETAILS:

M/AID NAME: _____MEMBERSHIP NO:_____

OPTION/PLAN: _____ GAP COVER: YES _____ NO_____

GENERAL: (Details of friend or relative at a different address)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

TEL NO (H): _____ (W) _____ (CELL) _____

REFERRING DOCTOR: _____ PRACTISE NO: _____

I, _____ UNDERSTAND THAT I AM LIABLE FOR PAYMENT OF THIS ACCOUNT. I UNDERTAKE TO INFORM THE PRACTICE OF ANY CHANGE OF ADDRESS, CONTACT NUMERS, MEDICAL AID OR OTHER CIRCUMSTANCES. I AM AWARE OF THE FOLLOWING POINTS:

1. **IT IS MY RESPONSIBILITY TO SETTLE ALL ACCOUNTS NOT COVERED BY MY MEDICAL AID**
2. **I AM LIABLE FOR THE COLLECTING AND ATTORNEY/CLIENT FEES AFTER 90 DAYS**
3. **INTEREST WILL BE ADDED AT 20% PA TO ALL ACCOUNTS OVER 90 DAYS.**

SIGNED: _____ DATE: _____