P.A. Minnaar & Ass Inc **Quintamed** **Pract. nr. 0279412**

Main member of medical aid/account

Surname		Full names		Title	
Name known by		Languages		ID nr.	
Residential address					
Postal adress				Code	
E-mail address					
Cell phone number		Work phone number		Other nr	
Employer		Occupation			
Work address					
Allergies					

Medical aid details

Name of Medical Aid		Plan of medical aid	
Membership number			

I hereby declare that I am solely responsible for the account, even in the event that the medical aid neglects or refuses to pay. I also declare that the information provided here is true and correct.
I authorize Quintamed, its staff or agents, any attending doctors and any attending healthcare professional to disclose the patient's medical records to all medical practitioners and member of the healthcare team who provide services to the patient or to whom the patient is referred to or from as well as Quintamed staff members who administer the practice. The patient further authorizes disclosure of the medical records to the patient's medical aid.

Signature		Date	

Dependants

Full name				
Name known by				
ID number				
E-mail address				
Cell phone number				
Occupation				
Allergies				

I hereby declare that we are responsible for the account, even in the event that the medical aid neglects or refuses to pay. I also declare that the information provided here is true and correct.
I authorize Quintamed, its staff or agents any attending doctor and any attending healthcare professional to disclose the patient's medical records to all medical practitioners and member of the healthcare team who provide services to the patient or to whom the patient is referred to or from as Quintamed staff members who administer the practice. The patient further authorizes disclosure of records to the patient's medical aid.

Signature				
Signature date				

Next of Kin - not staying at same address

Full name		Phone nr.			
Address				Relationship	

2 Wag-'n Bietjiebos Ave Pellissier

QuintaMed

ontvangs@quintamed.co.za