PATIENT INFORMATION

SURNAME

FIRST NAME TITLE

DATE OF BIRTH

SEX AGE

ADDRESS

CODE

TEL. (H) (W)

NEAREST RELATIVE/FRIEND

NAME

RELATIONSHIP

ADDRESS

CODE

TEL. (H) (W)

PERSON RESPONSIBLE FOR ACCOUNT PAYMENT

NAME

I.D. NO.

POSTAL ADDRESS

CODE

EMPLOYER

ADDRESS

CODE

TEL. (H) (W)

MEDICAL AID

NUMBER

MEMBER

PAST MEDICAL HISTORY

CONGENITAL

ALLERGIES ASTHMA

DRUGS

DIABETES

RHEUMATIC FEVER

SMOKE ALCOHOL

MEDICATION

OTHER

CUSTOMER NO.

FIRST DATE SEEN

PROBLEMS/DIAGNOSIS

DOCTORS

REFERRING

ADDRESS

CODE

TEL

G.P.

ADDRESS

CODE

TEL.

PAST SURGICAL HISTORY DATE

CORRESPONDENCE

DATE	DOCTOR	SUMMARY	DATE	DOCTOR	SUMMARY

A B C D E F G H J K L M N O P Q R S T U V VAN W XYZ

0 1 2 3 4 5 6 7 8 9