Dr Allan A van Zyl

DR ALLAN A VAN ZYL INCORPORATED
Orthopaedic Surgeon / Orthopediese Chirurg
Practice Number / Praktyk Nommer : 028 000 0391522

MEDICAL QUESTIONS

Name and Surname :	Age :
Length :	Weight :

PLEASE REVEAL ALL MEDICAL INFORMATION:

	YES	NO	SPECIFY IF YES
Any family members treated before?			
Lost weight recently?			
Any pain when walking? How far can you walk?			☐ Less than 2 km ☐ 2-5km ☐ 5-10km ☐ More than 10km
Heart conditions?			
Circulation problems in your legs?			
Hypertension?			
Blood clot in your legs or lungs? (Or family history thereof?)			
	YES	**NO**	
Any lung problems?			
Do you smoke?			
Have you had a stroke?			
Jaundice or any other liver problems?			
Ever had a peptic ulcer?			
Urine or bladder problems?			
	YES	**NO**	
Do you have HIV/AIDS?			
If no, have you been tested?			
	YES	**NO**	
Are you a diabetic?			
Thyroid gland problems?			
Any cortisone treatment in the past?			
Do u have gout?			
Ever had kidney stone?			
Ever had cancer?			

COVID 19:	YES	NO	
Previously had COVID infection?			When?

Medication that you are presently using:

Are you allergic to any drugs? Please list:

Please list previous operations:

PHYSICIANS CONSULTED IN THE LAST 10 YEARS

General Practitioner	
Specialist Physician	
Cardiologist	
Any other Doctors if applicable	

Name and Surname : ____ **Date :** ________________________

Signature : ____

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PATIENT DETAIL / PASIENT INLIGTING			
Surname / Van :		First Name / Volle Name :	
Gender / Geslag :	DOB / GEB :	ID :	
Tel Numbers/ Nommers :	(H) :	(W) :	(C) :
Email / Epos :			
Martial status / Huwelikstatus :		Occupation / Beroep :	
Postal Address / Posadres :		**Street Address / Straat Adres :**	
	Code / Kode :		Code / Kode :

MAIN MEMBER OR PERSON RESPONSIBLE FOR ACCOUNT / HOOFLID OF PERSOON VERANTWOORDELIK VIR REKENING			
Surname / Van :		First Name / Volle Name :	
Gender / Geslag :	DOB / GEB :	ID :	
Tel Numbers/ Nommers :	(H) :	(W) :	(C) :
Email / Epos :			
Employer / Werkgewer :		Occupation / Beroep :	
Postal Address / Posadres :		Employer Address / Werksgewer Adres :	
	Code / Kode :		Code / Kode :

NEXT OF KIN / NAASBESTAANDE PERSOON :	
Surname / Van :	First Name / Voornaam :
Cell / Sell :	Relation / Verwantskap :

MEDICAL AID DETAILS / MEDIESE FONDS BESONDERHEDE :	
Medical Aid / Mediese Fonds :	Plan / Plan :
Number / Nommer :	Dependant code / Afhanklike Kode :

GAP COVER / MEDICAL INSURANCE / MEDIESE ASSURANSIE	
Name / Naam :	Number / Nommer :

REFERRAL DOCTOR & GENERAL PRACTIONER / VERWYSINGS DOKTER & ALGEMENE PRAKTISYN	
Referral Doctor / Verwysings Doktor :	General Practioner / Algemene Praktisyn

PLEASE TAKE NOTE / NEEM ASSEBLIEF IN KENNIS
This is a Private Practice, and our fees may exceed your insured benefits. **Hierdie is 'n Privaat Praktyk en ons fooi mag u fondsvoordele oorskry.** **I undertake to request an account and if I do not receive one, I accept full responsibility for payment thereof should the medical aid not settle the account.** **Ek onderneem om 'n rekening te versoek en, indien ek nie een ontvang nie, aanvaar ek volle verantwoordelikheid vir betaling daarvan indien die Mediese Fonds nie die rekening vereffen nie.**

Signature / Handtekening : _____________________________ Date / Datum : ____

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PLEASE COMPLETE THE FOLLOWING CONDITIONS OF SERVICE. THIS PRACTICE IS ADMINISTRATED BY EXECUTIVE PRACTICE MANAGEMENT CC

CONDITIONS FOR SERVICE

I, the undersigned, the patient, legal guardian or guarantor of the patient referred to overleaf, hereby:

1. Undertake as principal debtor, alternatively bind myself jointly and/ or severally with the patient, to pay any claim of the Practice arising from medication, medical suppliers and/or services rendered or to be rendered to the patient, notwithstanding the existence of medical aid or insurance covering the claim;

2. Acknowledge that all accounts are payable on the rendering thereof, and that any accounts in arrears by more than 20 days will, subject to the maximum rate of interest as prescribed by the National Credit Act, 2005 from time to time, bear interest at the prime overdraft rate of the Practice's bankers from time to time;

3. Undertake, in the event of an account being unsettled for any reason and being referred to attorneys for collection, to be jointly and severally liable for the payment of all cost on an attorney and own client scale, all collection commission and all tracing cost, subject to the maximum fees and charges as prescribed by the National Credit Act, 2005 from time to time. All outstanding amounts will be recovered in the following order: interest, fees or charges and lastly capital;

4. Warrant, if applicable, that:

4.1. I am a bona fide member of the stated medical aid scheme;
4.2. The patient is a bona fide member/dependant:
4.3. There are preference funds available for such patient;
4.4. I have not been sequestrated and do not suffer from any legal or contractual disability;
4.5. The information recorded overleaf is correct;

5. Authorise the Practice or agent of the Practice to present for payment to the said medical aid scheme any account owed to the Practice. Notwithstanding the aforesaid, it is specifically recorded that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. The Practice nor its agent shall incur any liability in instances where accounts are not submitted to the medical aid scheme timeously.

6. Choose domicilium citandi et executandi at my physical address on the overleaf;

7. Authorise the Practice, or its agents, to provide information concerning the patient's treatment and/or medication to the patient's medical aid scheme, managed health care organisation or insurer and their respective agents and employees dealing therewith. Should any of the aforementioned parties also be the patient's employer, then I understand that the information may also be made available to the patient's employer;

8. Acknowledge that a certificate:

8.1. Signed by any doctor of he Practice shall be prima facie proof of the patient's indebtedness to the Practice;
8.2. Signed by any manager of the Practice's bankers (whose appointment need not be proved) shall be prima facie proof of the interest rate referred to in 2 above;

9. Acknowledge that I sign these conditions willingly and without duress and that no warranties or representations have been made by the Practice or any of its employees regarding the contents hereof;

10. Acknowledge that these conditions shall apply to all medication, medical supplies and services rendered or to be rendered by the Practice to the patient until cancelled by me in writing under the Practice's signed acceptance.

Name & Surname / Name & Van : _______________________________

Signature / Handtekening : _____________________________________