TRAUMA · SHOULDER
DR RENIER KRIEL
ORTHOPAEDIC SURGEON
MBChB (Stell), MMed (Orth) (Stell), FC Orth (SA)

021 861 6580
admin@orthokriel.co.za
Pr nr. 1104144
Suite G2
Mediclinic Winelands Orthopaedic Hospital
c/o Saffraan & Rokewood Avenue
Die Boord, Stellenbosch, 7600

WWW.ORTHOKRIEL.CO.ZA

MAIN MEMBER INFORMATION:

* ID NUMBER: | * SURNAME:
* FULL NAMES:
INITIALS: | GENDER: M F | TITLE: | * DATE OF BIRTH: C C Y Y M M D D
HOME LANGUAGE: | EMPLOYER:
* CELL NUMBER: | HOME NUMBER:
WORK NUMBER: | FAX NUMBER:
E-MAIL ADDRESS: | E-MAIL STATEMENT? Y N
* POSTAL ADDRESS:
* POSTAL CODE:
PHYSICAL ADDRESS:
POSTAL CODE:

* MEDICAL SCHEME:
* PLAN/OPTION: | GAP COVER: Y N
* MEMBER NO.: | MAIN MEMBER DEP CODE:

PATIENT INFORMATION:

* ID NUMBER: | * SURNAME:
* FULL NAMES: | NICK NAME:
INITIALS: | GENDER: M F | TITLE: | * DATE OF BIRTH: C C Y Y M M D D
HOME LANGUAGE:
* CELL NUMBER: | Use this number for appointments / test results Y N
Main member's Cell Phone number will be used if the above is ***No***
HOME NUMBER: | WORK NUMBER:
E-MAIL ADDRESS:
OCCUPATION: | MARITAL STATUS:
RELATIONSHIP TO MAIN MEMBER: | * PATIENT DEPENDANT CODE:
AGE: years | HEIGHT: , m | WEIGHT: kg
REFERRING DR: | TEL. NO.:
GP: | TEL. NO.:

NEXT OF KIN: *(Not from the same physical address)*

INITIALS: | TITLE: | SURNAME:
FULL NAMES:
CELL NUMBER: | RELATIONSHIP TO PATIENT:

Hereby I confirm that the information I supplied is true and I am responsible for any false information provided

* NAME IN PRINT:
* DATE OF SIGNATURE: C C Y Y M M D D
* SIGNATURE: _____

All fields with * are mandatory. Please note that you (or your parent/guardian) remain liable for the account for services rendered by this practice, even if you are insured by a medical aid or other third party. Please ensure that you have read and signed the attached Doctor-Patient contract.