CONFIDENTIAL:	QUESTIONNAIRE FOR NEW PATIENTS		
MEDICAL AID NAME:		MEMBERSHIP NO.	

MAIN MEMBER / GUARANTOR

Prof / Dr / Mr / Mrs / Miss / Ms / Other: ____________________

Full First Name: ____________________

Surname: ____________________

Occupation: ____________ Present Employer: ____________ For years: ____________

I.D. Nr. ____________________ Date of birth: ____________

PLEASE CIRCLE
Single / Widowed / Divorced / Married Antenuptial Contract / Community of Property / Partner

Residential Address: ____________________

____________________ Postal Code: ____________

Contact Tel: (H) ____________________ (B) ____________________

Mobile: ____________________

E-mail Address: ____________________

Preferred Method of Communication:

- ☐ Phone
- ☐ E-mail
- ☐ SMS / Whatsapp

NAMES AND DETAILS OF DEPENDANTS:

Husband / Wife / Partner: ____________________ D.O.B. ____________

Name: ____________________ D.O.B. ____________

Children:
1.) ____________________ ____________
2.) ____________________ ____________
3.) ____________________ ____________
4.) ____________________ ____________
5.) ____________________ ____________

REFERRED BY: ____________________

WE ARE CONTRACTED OUT OF MEDICAL AID.
PLEASE PAY US DIRECTLY AND THEN CLAIM YOUR
PORTION FROM YOUR MEDICAL AID.

BY SIGNING THIS DOCUMENT YOU TAKE FULL
RESPONSIBILITY FOR THIS ACCOUNT AND PAYMENT.

FAILURE TO CANCEL AN APPOINTMENT AT LEAST 24 HOURS
IN ADVANCE WILL RESULT IN A FEE BEING CHARGED TO YOUR ACCOUNT.

Dr. Liezl Kemp & Associates
Dental Surgeon / Tandarts

DATE: ____________________ SIGNED: ____________________