ADÈLE GREYLING
ELECTROPHYSIOLOGIST & CARDIOLOGIST

MBChB, MRCPCH(UK), FCPaed(SA), Cert Cardio(SA)Paed
European Heart Rhythm Association Certified Cardiac Device
and Invasive Electrophysiology Specialist

MP 0522368 | PN0130323500

PATIENT INFORMATION					
Title:	Surname:		Initials:	Name:	
Date of Birth:	Age:	Identity Number:			Gender:
Email Address:		Cell Number:		Work Number:	
Referring Doctor:			General Practitioner:		
Referring Doctor Tell Number:			General Practitioner Tell Number:		
Allergies:		Medication:			
Existing Device: ICD ___ Pacemaker ___ Loop Recorder ___			Brand/Manufacturer:		

MAIN MEMBER OF MEDICAL AID / PERSON RESPONSIBLE FOR THE ACCOUNT					
Title:	Surname:		Initials:	Name:	
Date of Birth:	Age:	Identity Number:			Gender:
Email Address:		Cell Number		Work Number:	
Employer:			Occupation:		

Telephone 021 840 7263 | **Email** dradelegreyling@gmail.com

MEDICLINIC VERGELEGEN Block 3, Suite 18, 70 Main Road, Somerset West, 7130

Physical Address:

ADELE GREYLING
ELECTROPHYSIOLOGIST & CARDIOLOGIST

Postal Address:

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Preferred method for communications from the practice: SMS Email Telephonically

MEDICAL AID DETAILS

Medical Aid:	Benefit Plan / Option:	Medical Aid Number:	Patient Dependant Code:
Does your medical aid include GAP cover, or do you have GAP cover?			
Main Member Name and Surname:		Main Member Identity Number:	

I confirm that there are no active exclusions or waiting periods that applies to either myself and/or the patient: ____

NEXT OF KIN / IN CASE OF EMERGENCY CONTACT

Name and Surname:	Relationship to patient:	Contact Number:
Name and Surname:	Relationship to patient:	Contact Number:

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Terms & Conditions:

1. The above information is true to the best of my knowledge.
2. I authorize the practice to present for payment to the medical aid scheme any account owed to the practice in respect of the patient or me.
3. I understand that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. The practice shall incur no liability in instances where accounts are not submitted to the medical aid scheme timeously.
4. I also authorize Dr A Greyling to release any information required to process my claims.
5. I have acquainted myself with all the terms and tariffs applicable and have noted that:
    a. The terms and a copy of the tariffs applicable to private patients are available from reception;
    b. The terms and tariffs for patients covered by medical aid schemes vary. I understand that I must communicate directly with my medical Aid scheme for the benefits available to me.
6. I undertake, in the event of an account being unsettled for any reason and being referred to attorneys and / or collection agency for
collection, to be jointly and severably liable for the payment of all costs on an attorney and own client scale, all collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorney's, collection agency fees, collection commission, tracing fees, interest and lastly capital.
7. I hereby warrant that (if applicable):
    a. The patient is a bona fide member of the medical aid scheme mentioned herein and his / her membership is valid as at the date of the signature of this agreement; or
    b. I am a bona fide member of the medical aid scheme mentioned herein and my membership is valid as at the date of the signature of this agreement, and the patient is a bona fide dependent in terms of such membership; and
    c. I confirm that there are no active exclusions or waiting periods that applies to either the main member and or the patient; and
    d. I have not been sequestrated and do not suffer from any legal or contractual disability.
8. I choose as domicilium citandi et executandi the address detailed on the front page of this application form.
9. I confirm that the practice may provide a credit bureau with all information regarding these conditions and any non-compliance with the terms thereof by me. I also confirm that the credit bureau may supply a credit profile and a possible credit rating based on the credit worthiness of me to the practice.
10. No alteration or deletion of any part of this document shall be effective unless the practice signs next to each variation or deletion.
11. I confirm that:
    a. I affixed my signature hereto willingly and without any duress;
    b. I agree to these conditions; and
    c. No misrepresentation with regards to the content hereof has been made.
12. I have been informed of the Financial Policy & Privacy Policy.
13. We hereby request your permission to forward medical reports and test results to the Doctors involved in your treatment. We would also be requesting previous medical reports and test results from Doctors/Laboratories who were involved in your treatment. All these will be done via Fax or Email.
14. We hereby request your permission to forward a letter of motivation and/or clinical report and/or supporting document to your medical aid if needed, to obtain authorization for any planned medical/surgical management.

Patient/Guardian signature: _____ Date: _____

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Responsible Person / Main Member signature: _____ Date: _____

Patient Confidentiality Disclosure

Title:	Surname:	Initials:	Name:

Date of Birth:	Age:	Identity Number:	Gender:

Email Address:	Cell Number	Work Number:

Physical Address:	Postal Address:

I, the undersigned, being the patient or legal guardian of the patient hereby authorise the practice of Dr A Greyling, who is in possession of information concerning my medical diagnosis and treatment together with my health and personal details; to disclose such information to my Healthcare Funder and other Healthcare Providers.

We hereby request your permission to forward medical reports and test results to the Doctors involved in your treatment. We will also request previous medical reports and test results from Doctors / Laboratories who were and might still be involved in your treatment. All these will be done via Fax or Email.

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We hereby request your permission to forward a letter of motivation and/or clinical report and/or supporting documents to your medical aid if needed, to obtain authorisation for any planned medical/surgical management.

I further wish to indicate that this consent was given out of my own free will without any undue influence from Dr A Greyling.

Signed: _____, at _____, on _____ of _____ 20___.

Our practice follows the 8 National Privacy Principles (NNPs) contained in the Protection of Personal information Bill. These NPPs set out how information may be collected and used, and the rights and responsibilities of the various parties in the collection, storage and use of that information.

Collection
Information collected by our practice about a patient is intended to be used only for the purpose of providing the best possible standard of health care to that patient. This information may include information specifically about their general health and the health of their relatives. Information will generally be collected directly from the patient, although in some cases it will be necessary to obtain information from others, for example the patient's referring cardiologist or general practitioner. Our practice and/or our staff will answer any queries the patient may have about the information being collected or the reason that it is being collected.

Processing limitation
Information provided by a patient will be used for the benefit of that patient in particular to provide them with the highest possible standard of healthcare. In some cases, this may require providing information about the patient to another health care practitioner, for example, when a patient is referred to us for treatment. When this occurs, the patient will be informed that the information is being provided. Information will be released when we are legally required to do so. In most cases this will require a court to order the release of the information, although information may also be released when we believe that this is necessary to prevent a serious and imminent threat to a person's life, health, or safety, or to public health and safety. Some information, such as the patient's identity and the type of consultation provided, may be released in order to allow medical aid scheme benefits to be claimed.

Purpose specification
We collect information for a specific, explicitly defined, and lawful purpose intended to be used only for the purpose of providing the best possible standard of health care to the patient. Our practice does not retain

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records of personal information any longer that it necessary for archiving the purpose of which the information was collected or subsequently processed unless retention of the record is required or authorised by law.
The practice reasonably requires the record for lawful purposes related to its function or activities.
Retention of the record is required by a contract between the parties thereto; or
The patient has consented to the retention of this record.

Data quality
Our practice will make all reasonable efforts to ensure that the information held about the patient is complete, accurate and up to date. When a patient informs us of inaccuracy, it will be corrected as soon as possible.

Patient/Guardian signature: _____ Date: _____

Responsible Person / Main Member signature: _____ Date: _____

NEW PATIENT – IMPORTANT MEDICAL INFORMATION

Name & Surname: _____ ID/Date of Birth: _____

What is the main reason for your visit?

_____

_____

_____

Do you have any of the following symptoms?

- ☐ Dizziness
- ☐ Palpitations
- ☐ Collapse
- ☐ Shortness of breath
- ☐ Snoring

Do you have any of the following conditions?

- ☐ Hypertension
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Asthma

Has your Thyroid been checked recently?

☐ Yes ☐ No If yes when? _____

Do you have Coronary Disease?

☐ Yes ☐ No

Does your family have a history of heart disease?

☐ Yes ☐ No

Have you had an Angiogram recently?

☐ Yes ☐ No If yes when? _____

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Do you have any other Serious/Chronic Illnesses?

_____

_____

Do you take any medication? (Please list below or bring the medication along to your appointment)

_____

_____

Do you have any Allergies?

☐ Yes ☐ No If yes please list below.

_____

Please list any/all past surgeries you've had (female patients please include Gynaecological history as well)

_____

_____

What do you do for a living?

_____

Social:

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Do you drink? ☐ Yes ☐ No If yes, how often? _____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____

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