DRS CAWOOD, HOSKING, MACROBERT, FENWICK, FRANKEN & KING

Please complete only ONE form per family:

PERSON RESPONSIBLE FOR THIS ACCOUNT Account Number:

Surname:	Initials:	Title:
First Name (of main member):	I.D.	
Postal Address:		
	Postal Code:	
Physical Address (if different):		
Employer:		
Work Address:		
Home Tel No.:	Work Tel No.:	
Cell Phone No.:	Fax No.:	
Position in Firm:	Spouse Work No.:	
E-Mail Address:		

MEDICAL AID DETAILS (Please show medical aid cards)

Name:	Option:
Main Member:	Number:

FAMILY or FRIEND (Not from same household)

Name & Surname:	
Address:	
Relationship:	Tel No. & Code:

FAMILY DETAILS - ALL PATIENTS ON MEDICAL AID CARD PLEASE

Name:	Nick Name:	Date of Birth:	Dependant Number:

Patient agreement:

I confirm that the above information is true and correct. I undertake to inform you of any changes thereto within 14 days of a change occurring.

I undertake to forward all statements to my Medical Aid and to settle all accounts that have not been paid by the Medical Aid society.

I TAKE FULL RESPONSIBILITY FOR THE ACCOUNT.

I take note of the fact that in the event of non payment by 90 days my name will be added to the ITC list of bad payers.

I accept that in the event of my non-compliance with the above undertaking I will be held liable for payments of all costs incurred in collecting such moneys from me as between attorneys and client including collection commission and tracing costs.

SIGNATURE:..... DATE:.....