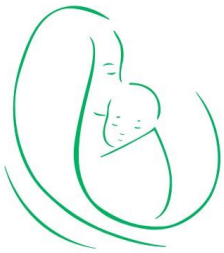

Dorle Verrinder
Registered Dietitian

Patient Details Form

Patient

Surname	First Name
If patient is a child, name of Parent/Guardian:	
Date of Birth	Name of GP/Doctor/Paediatrician
Cell No.	Referrer / How did you hear about me?
Alternative Tel. No.	Profession
Email Address	ID number

Person responsible for Account *(Medical Aid Clients)*

◯ **I am a Private Patient**

Surname (name of Main Member)	First Name
Residential Address	Postal Address
Medical Aid Name	Option / Plan
Medical Aid Number	

Terms and Conditions

Medical aid rates will be charged and a copayment applies to each consultation. Fees for dietetic services will be submitted directly to your medical aid. If for some reason the medical aid does not pay for some or all of the fees charged for dietetic treatment received, the account holder will undertake to pay all accounts outstanding.

It is often necessary to share information with other health professionals involved in the client's medical care in order to treat the client in a holistic manner. Please indicate whether the dietitian has your permission to share information with other health professionals involved in your care.

◯ **Yes you can share relevant information with other health professions.**

I have read and understood and agree to these terms and conditions. The information I have provided is correct.

Signature (Patient or Guardian) _____ Date _____