Dr's PE Eramus & J DO Vale Inc

Registration Form

Phone: (031) 7822030
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Practice Number: 1526642

PO BOX 213
CATO RIDGE
3680

Date: ______ / ______ / ______

PARTICULARS OF PERSON RESPONSIBLE FOR PAYMENT "main account holder"

ID Number: | | | | | | | | | | |

Date Of Birth: ______ / ______ / ______

Gender: ______ **Language:** ______ **Title:** ______ **Initials:** ______

Surname: ______________________ **First Names:** ______________________

CONTACT INFORMATION

Physical Address		Postal Address		Next of kin Address (not living with you)	
Address:		**Address:**		**Address:**	
City:		**City:**		**City:**	
Suburb:		**Suburb:**		**Suburb:**	
Post Code:		**Post Code:**		**Post Code:**	
Home No.		**Cell No.**		**Next of Kin:**	
Work No.		**Fax:**		**Kin No.**	

E-mail: ______________________ **Work Address:** ______________________

Occupation: ______________________ **City:** ______________________

Employer: ______________________ **Post Code:** ______________________

I the undersigned, as main account holder, on behalf of all individuals authorised to use my account including myself ("my Authorised Users") hereby authorise the Practice to process our encrypted personal and health data and transmit it to third parties, for example, medical schemes, administrators, pharmacies, and insurers for further processing, solely for the purpose of providing us with digital integrated health care. I acknowledge that every such process or transmission will be treated as though authorised by one of my Authorised Users. I warrant that

Signed at ______________ **this** ________ **day of** ____________ **year** ____________ **Account Holder** ______________