DR ANTHONY YIP INC
CARDIOLOGY PRACTICE INC
SUITE C28, LIFE FOURWAYS HOSPITAL,
CNR. CEDAR RD AND CEDAR AVE WEST
FOURWAYS
2055
MP NUMBER:0489603
PRACTICE NUMBER: 0210000246883

FILE NO. _____

PARTICULARS OF PATIENT

SURNAME _____ NAME _____ INITIALS _____ TITLE _____

GENDER _____ DATE - BIRTH _____ ID NO. _____

RESIDENTIAL ADDRESS _____

POSTAL ADDRESS _____

TEL: (H) _____ (W) _____ (M) _____

FAX _____ E-MAIL _____

I hereby accept that email ☐ YES ☐ NO
and/or sms ☐ YES ☐ NO messages may be sent to me in order to confirm appointment and convey general information of the practice and my healthcare (e.g. to pick up test results).

OCCUPATION _____ EMPLOYER (CO NAME) _____

REFERRED BY _____

NAME, ADDRESS & TEL NO. OF A FAMILY MEMBER / FRIEND: _____

_____

(for account purposes should we be unable to contact you)

MAIN MEMBER OF MEDICAL SCHEME

(please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)

SURNAME _____ NAME _____ INITIALS _____ TITLE _____

GENDER _____ DATE OF BIRTH _____ ID NO. _____

ADDRESS _____

TEL: (H) _____ (W) _____ (M) _____

OCCUPATION _____ EMPLOYER (CO NAME) _____

MEDICAL SCHEME _____ NO. _____

E-MAIL ADDRESS _____

Terms and Conditions of the Practice

By signing this form, you acknowledge that you have understood and agreed to the following:

1) That you have received a copy of the terms and conditions (provided separately) and have had an opportunity to ask questions on aspects thereof that you were not certain about.
2) To abide by the terms and conditions of the practice, in particular the provisions on the payments of accounts.
3) To always ask, even after you have left the practice, if you were uncertain about something. You can ask practice staff or the doctor. If you keep quiet, practice staff and the doctor will assume that you ahve understood everything and were in agreement with any processes, consents, policies or forms.
4) **If you do not keep your appointment (for any reason whatsoever, apart from emergencies) and you have not let us know at least 24 hours before the appointment, we reserve the right to charge a cancellation fee, as we have kept the slot open for you and could not assist another patient.**

_____ _____ _____

SIGNATURE DATE WITNESS