## PLEASE COMPLETE THE FOLLOWING FORM AND EMAIL IT TO: reception@sedationspecialists.co.za

| ***PATIENT:*** | | | | ***PERSON RESPONSIBLE FOR ACCOUNT:*** | |
|---|---|---|---|---|---|
| Name of Patient: | M | F | | Name of Person Responsible for Account: | |
| Date of Birth: | Age: | Patient weight: _____kg | | ID of Person Responsible for Account: | |
| Date of Operation: | Type of Operation: | | | Relationship of person responsible for account to patient: | |
| **Allergy** to medicine? / injections? / food? | Yes | No | | Home Address: | |
| Porphyria? / Malignant Hyperthermia? / Scoline apnea? | Yes | No | | Postal Address: | |
| Cortisone treatment in the past 12 months? | Yes | No | | | |
| Premature birth? / Any problems at birth? | Yes | No | | Telephone numbers:(h) | (w/cell) |
| Asthma or bronchitis? | Yes | No | | Email Address: | |
| Heart Disease? / Heart Murmurs? | Yes | No | | Medical Aid Plan: | Medical Aid Number: |
| Diabetes or thyroid problems? | Yes | No | | | |
| Jaundice? / Kidney disease? / Bladder disease? | Yes | No | | Dependency code: | Authorization Code: |
| Epileptic convulsions? / Blackouts of any sort? / ADHD? / Autism? | Yes | No | | | |
| Sleep apnoea? / Snoring? | Yes | No | | List **ALL** Medication with dosage, please: (including **Herbal** and **Recreational** drugs**)** | |
| Recent Cold or Flu? / Fever? / Runny Nose? / (in the last 2 weeks) | Yes | No | | List **ALL** previous Operations**:** | |
| Tendency to bleed or bruise easily? | Yes | No | | | |
| Problems with previous Anaesthetics or Sedation? | Yes | No | | | |
| Please give details of questions answered **YES:** | | | | | |
| | | | | *Anything that you want to discuss with your Anaesthetist and **not** write down:* Y N | |
| | | | | Your GP or Paediatrician's name and contact number: | |

**YOUR ACCOUNT:** You will receive a separate account from your Anaesthetist. We charge private fees, based on Discovery Anaesthetic rates. This is in line with guidelines of the South African Health Professions Council and recommendations of the Medical Association of South Africa**.** After your procedure, your account will be transmitted electronically to your Medical Aid and you will receive an email to confirm payment. You are ultimately responsible for the settlement of your account should the medical aid neglect to pay. Private Patients will receive an invoice after the procedure at rates as described above and detailed per e-mail.

**TERMS AND CONDITIONS OF PAYMENT:**

I accept full and complete responsibility for actual and potential costs associated with conscious sedation or General Anaesthesia. I accept full responsibility for the costs that have been explained to me. If the account is sent to the medical aid, the person responsible for the account is liable for the full amount, even if the medical aid short pays, for whatever reason. I accept full responsibility for the account if I am not the main member but the person completing this form in case of non-payment from the main member. Failure to settle the account on request will result in the account being handed over for collection. You will be responsible for any extra costs thereafter – for collection fees 20%,25%, 35%, 50% etc. Interest will be charged at 2% per month on accounts of 90 days and older, which you are responsible for. I agree to comply with the terms and conditions of payment. I confirm that the person responsible for paying the account has been informed of the costs, if it is not the same person signing this form.

| SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT | SIGNATURE OF PARENT / GUARDIAN | DATE: |
|---|---|---|
| | | |

I / We have read the information on this form and understand the content.

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