Account Enquiries
Rekening Navrae
☎ 021 595 2515
: 021 595 1770
✉ 12716, N1 City, 7463
Email:
accounts@bergmanross.co.za

BERGMAN · ROSS & PARTNERS
BR&P
RADIOLOGISTS

N1 CITY HOSPITAL
GOODWOOD
☎ 021 595 1370

KUILS RIVER HOSPITAL
KUILS RIVER
☎ 021 900 6600

PR No.: 380 3465

PATIENT INFO:

TITLE: _____

FIRST NAMES: _____

SURNAME: _____

SEX: _____

D.O.B: _____ AGE: _____

MOBILE NUMBER: _____

ID NUMBER: _____

E-MAIL: _____

ALLERGIES: _____

ASTHMA: ☐

PREGNANT: ☐

MEMBER INFORMATION:

TITLE: _____

FIRST NAMES: _____

SURNAME: _____

ID NUMBER: _____

MOBILE NUMBER: _____

EMAIL: _____

OCCUPATION: _____

PLEASE FILL IN THE MEDICAL DETAILS

MEDICAL AID NAME: _____

MEDICAL AID NUMBER: _____

MEDICAL AID PLAN: _____

DEPENDENT CODE: _____

AUTHORISATION CODE: _____

MEMBER
POSTAL ADDRESS: _____

EMPLOYER: _____

TEL(W): _____

TEL(HM): _____

MEMBER
HOME ADDRESS: _____

RELATIVE NAME'S: _____

EMAIL ADDRESS: _____

RELATIVE'S
CONTACT NUMBER: _____

HOSPITAL PATIENT: _____

HOSPITAL NUMBER: _____

WARD: _____

PRIMARY REFFERING DOCTOR: _____

SECONDARY REFFERING DOCTOR: _____

WCA: _____ DATE OF INJURY: _____

CLAIM NUMBER: _____

COMPANY DETAILS
ADDRESS: _____

CONTACT PERSON/TELEPHONE NUMBER: _____

EXAMINATION (S):

INDEMNIFICATION AND CONSENT

I hereby give consent to the injection or administration of any Radiology contrast media or medication which my be necessary for the performance of my radiology examination ☐

Notwithstanding any Medical Aid Society or other organisation's undertaking.
I acknowledge personal responsibility for the payment of the account within 30 Days ☐

As a Private Patient and Patients without a valid medical aid, I agree to pay for the procedure/examination on the day. ☐

I authorise and give consent to Bergman Ross & Partners to release my medical reports, diagnostic images and referral letters for the purpose of mediating my radiology account with my medical aid as well as my referring doctor and other specialists ☐

I hereby give consent to disclose the diagnostic codes (regarding my illness)to either my medical aid or government institution for statistical purposes, as well as 3rd parties as pers condition of the POPI (PAIA) Act of 2013 YES NO

Patient Signature _____

Patient Name _____

Date _____