Cintocare
Suite 15
175 Frikkie de Beer Street
Menlyn Maine
Pretoria
0181

Dr. Johan van Heerden
PLASTIC AND RECONSTRUCTIVE SURGEON
012 993 0476
066 152 8919
Accounts: 082 305 1689 /
acc.johanvh@gmail.com
admin@drjohanvanheerden.co.za

MAIN MEMBER INFORMATION:

ID NUMBER: _____ SURNAME: _____
FULL NAMES: _____
INITIALS: _____ GENDER: MALE/FEMALE
HOME LANGUAGE: _____TITLE: _____ DATE OF BIRTH: _____
CELL NUMBER: _____ HOME NUMBER: _____
WORK NUMBER: _____ EMPLOYER: _____
EMAIL ADDRESS: _____ EMAIL STATEMENTS: YES/NO
POSTAL ADDRESS:

_____
_____ POSTAL CODE: _____
PHYSICAL ADDRESS:

_____
_____ POSTAL CODE: _____
MEDICAL SCHEME: _____
PLAN/OPTION: _____
MEMBER NUMBER: _____ DEPENDANT CODE: _____
GAP COVER: YES/NO DETAILS/PLAN/NUMBER: _____

PATIENT INFORMATION:

ID NUMBER: _____ SURNAME: _____
FULL NAMES: _____
INITIALS: _____ GENDER: _____TITLE: _____ DATE OF BIRTH: _____
CELL NUMBER: _____ USE THIS NR FOR APPOINTMENTS: Y/N
(MAIN MEMBER'S CELL PHONE NUMBER WILL BE USED IF ABOVE IS NO)
HOME NUMBER: _____
WORK NUMBER: _____ EMPLOYER: _____
EMAIL ADDRESS: _____
TYPE OF DEPENDANT: _____
MAIN MEMBER/SON/SPOUSE/DAUGHTER/MOTHER/FATHER/OTHER
DEPENDANT CODE: _____
HEIGHT(M): _____ **WEIGHT(KG):** _____
REFERRING DOCTOR: _____
ICD-10 CODE(S): _____
ONCOLOGIST (if applicable): _____

NEXT OF KIN:

SURNAME: _____
FULL NAMES: _____
INITIALS: _____ TITLE: _____
CONTACT NUMBER: _____RELATIONSHIP_____

MEDICAL QUESTIONNAIRE:

DO YOU SMOKE? HOW MANY/DAY & HOW MANY YEARS: _____
ARE YOU PREGNANT PRESENTLY? HOW MANY WEEKS? _____
PROFESSION: _____ HAND DOMINANCE: LEFT/RIGHT

MEDICAL HISTORY: *(PLEASE ANSWER YES/NO TO THE FOLLOWING AND IF YES PLEASE GIVE DETAILS)*
HYPERTENSION: _____
LUNG DISEASE (ASTHMA, EMPHYSEMA): _____
DIABETES (TYPE 1 OR 2): _____
HEART OR BLOOD VESSEL DISEASE? STENTS? _____
CHOLESTEROL? _____
PREVIOUS THROMBOSIS / EMBOLISM? WHERE? _____
KIDNEY OR BLADDER DISEASE? _____
JAUNDICE OR HEPATITIS (IF SO, WHEN?) _____
EPILEPTIC CONVULSIONS? _____
MUSCLE DISEASE OR STROKE? _____
THYROID DISEASE? _____
HIV POSITIVE? WHICH TREATMENT? _____
HERPES SIMPLEX INFECTION (FEVER BLISTER)? _____
ALLERGIC TO IODINE, PENICILLIN, LATEX OR ANY OTHER MEDICATION?
_____
PLEASE LIST ALL YOUR CHRONIC MEDICATION:
_____
_____
CHEMO/RADIATION THERAPY END DATE (if applicable) _____
_____

DO YOU USE ANY OF THE FOLLOWING AND IF YES PLEASE GIVE DETAILS?
1. CONTRACEPTIVE? _____
2. HERBS & VITAMIN SUPPLEMENTS? _____
3. CORTISONE, PLAVIX, CLOPIDOGREL, CLOPIWIN, WARFARIN, XARELTO, PRADAXA, GRANDPA, DISPRIN, ASPIRIN, VOLTAREN, NUROFEN OR BRUFEN?
_____
4. ROACCUTANE / ORATANE? _____

SURGICAL HISTORY:
PLEASE LIST YOUR PREVIOUS OPERATIONS, DATES & COMPLICATIONS:
_____
_____
_____

BREAST & ABDOMINAL SURGERY QUESTIONNAIRE: ***(ONLY FILL IF APPLICABLE)***
AMOUNT OF PREGNANCIES? _____ NUMBER OF CHILDREN? _____
BREAST FEEDING? _____ PRESENT BRA SIZE? _____
MAMMOGRAM/SONAR & DATE? _____
ABDOMINAL OR UMBILICAL HERNIAS? _____
FAMILY HISTORY OF BREAST CANCER? MOTHER/SISTER/FATHER/BROTHER _____

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CONFIDENTIALITY, POPIA and DATA RETENTION

All information handled by the practice is regarded and treated as strictly confidential by the healthcare professional and the practice staff. Legislation compels the practice to provide certain information on accounts, including diagnostic information. Failure to submit the correct codes might lead to the clam being incorrectly paid or rejected by your medical scheme of funder.
The Practice must also disclose ICD-10 codes on referral letters, requests for special investigations (e.g., radiology, pathology) etc.
In the event of a third-party request for confidential information from the practice, and in doubt regarding the safety of confidentiality process, the practice may insist on following the standard operating procedures legislated in any legislation.

You hereby consent in terms of the Protection of Personal Information Act 4 of 2013 ("POPIA") as amended from time to time, that the practice may share your personal information (including diagnostic information) for practice administrative services, including external practice administration providers contracted by the practice, historical, statistical, research purposes, or practice business planning with other service providers to enhance systems and services, this to include sharing with the personal information with other Healthcare Practitioners, Medical Schemes, Claim/Invoice Switch Houses in the course of providing the services to you. Your participation in this regard is highly appreciated.

You further herby consent that the Practice may contact you by any one of the following communication methods/platforms/systems ("communication"); namely: phone, sms, Email, social media platforms such as Whatsapp or similar services or any future communications. You understand that these communications will be used for professional communication only. This will include (but not limited to) accounts, statements and information, practice information, system updates, professional updates, prescriptions, and reports where necessary and indicated. You acknowledge that none of these communications are completely secure or encrypted communications, and you will not hold the Practice responsible for any breach of confidentiality via these communications.

Please tick the appropriate box(es):

☐ I understand the implication and agree that, where appropriate, the healthcare and practice may disclose my ICD-10 diagnosis code)s) under the conditions described above

☐ I understand the implications and request that the healthcare professional does not disclose the spesifics of my diagnosis. The healthcare professional is to use ID-10 code U98.0. (Patient refuse to disclose clinical information) In this case I assume full liability for the account in its entirety.

Signed: _____ Witness: _____ Date: _____
(Patient or person authorised to consent for patient)