DR JOHAN CHARILAOU
ORTHOPAEDIC SURGEON

T: 021 100 3840 | WhatsApp: 079 158 1581
E: admin@capeortho.co.za
A: Suite 209, Second floor
Mediclinic Cape Gate Hospital & Day Clinic
Corner of Okavango and Tanner Roads
Brackenfell, Cape Town, 7560

Patient Information

Please select the appropriate option below

☐ I am a new patient (please complete all sections below)
☐ I am an existing patient and wish to update my details (please complete only those sections that need to be updated)

Patient details

Name and surname: _____
ID number: _____
Gender: _____
E-mail address: _____
Residential address: _____
_____ Postal code: _____
Postal address: _____
_____ Postal code: _____
Home telephone number: _____
Cell phone number: _____
Profession: _____
Employer: _____
Work address: _____
_____ Postal code: _____
Work telephone number: _____
Body mass index (BMI): Length: _____ Weight: _____

By signing this form, you hereby consent that your parent(s) or guardian(s) may be present at the consultation and that they may share your information with the practice.

Medical aid details

Medical aid: _____
Medical aid plan: _____
Membership number: _____
Dependent number: _____
Gap cover: _____
Underwriter: _____
Reference number: _____

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Main member details

☐ Same as patient details

Name and surname: _____
ID number: _____

Gender: _____

E-mail address: _____
Residential address: _____
Postal code: _____
Postal address: _____
Postal code: _____
Home telephone number: _____
Cell phone number: _____
Employer: _____
Profession: _____
Work address: _____
Postal code: _____
Work telephone number: _____

Next of kin

Full name: _____
Telephone number: _____
Relationship: _____

Referring doctor or general practitioner

Name and surname: _____
Telephone number: _____
E-mail address: _____
Practice address: _____

If not referred – how did you obtain my details?

☐ Social media
☐ Friends/Family
☐ Google
☐ Other

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Consent for communication

SMS / WhatsApp: To confirm an appointment
E-mail: To e-mail accounts, quotations etc

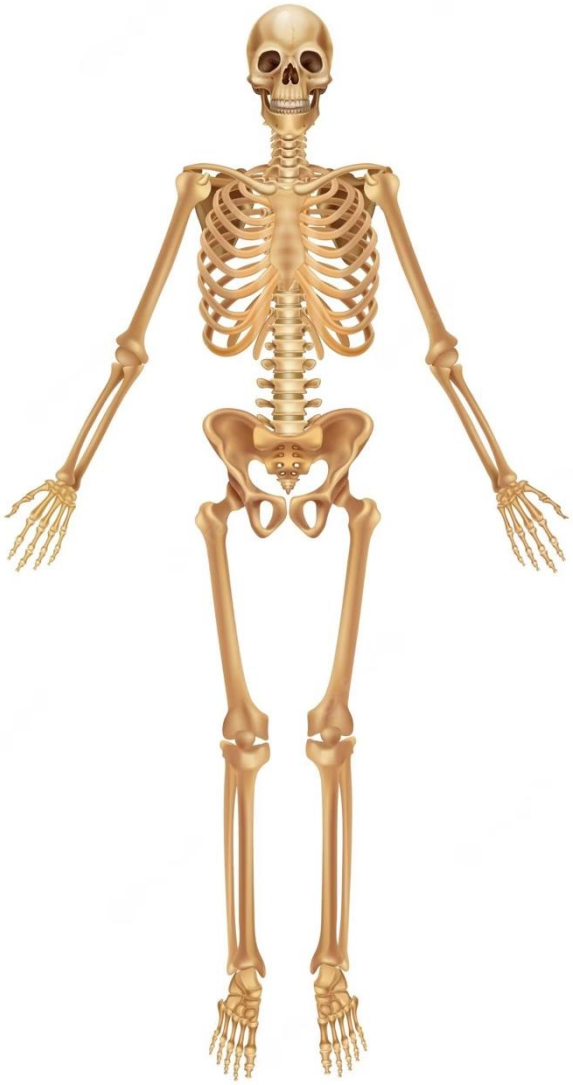
☐ Yes ☐ No

Medical background

Main complaint:

Indicate on diagram below where your pain / injury or main complaint is:

RIGHT LEFT



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Anatomical site and side: _____
Mechanism of injury: _____
Date of injury: _____

Spontaneous onset: _____
Duration of symptoms: _____
_____
_____

Symptoms:

- Describe symptoms in own words
- Pain
  If yes:
  - ☐ Does pain start or go elsewhere
  - ☐ Night pain
  - ☐ Improvement on pain medication or not
  - ☐ Frequency of pain:
  - ☐ Movement or rest improves pain:

- Deformity
- Swelling
- Stiffness
- Loss of function
  Impact on:
  - ☐ Activities of daily living
  - ☐ Sport and recreation
  - ☐ Stairs
  - ☐ Work
  - ☐ Sleep

- Limited movement: explain

  _____
  _____

Management:

- ☐ Physio- or other therapy:
- ☐ Pain medication and effect:
- ☐ Splinting or cast:
- ☐ Crutches / walking frame:
- ☐ Previous surgery for same problem:
- ☐ Other:

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Radiology done (Xray/MRI): where and when

Dominant hand: left or right

Previous Surgery:

- Type:
- Date:
- Surgeon:

Medical history:

- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Gout
- ☐ Thyroid dysfunction high or low
- ☐ Heart stents or bypass
- ☐ Heartburn
- ☐ Cancer
- ☐ Other:

Current medication:

Name, dose and frequency per day:

Please indicate if you are on blood thinners:

Allergies:

Social history:

Smoking per day
Alcohol per day
Sports activities and intensity
Hobbies

What are your expectations for management:

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General
This document explains the general conditions under which this practice sees patients. It does not constitute an informed consent to any specific treatment, nor a quotation or price for any service rendered by the practice. Informed consent and price information can be provided each time you visit the practice and will depend on the care you need or seek, and other factors such as your medical scheme cover. Please note that all consultation fees are payable on the day of the consultation and patients are responsible for claiming it back from their medical aid. Please note that we are only contracted in with **Discovery Classic Plans.**

Other healthcare professionals
You hereby provide consent for the exchange of personal and clinical information between all relevant or referring healthcare professionals, doctors, hospitals, medical schemes, and their administrators or appointed managed care organisations. This serves as a binding contract between you, the patient, and this practice. You further consent to us communicating with third parties who have undertaken to indemnify you for the costs of your treatment, and management or part thereof, including medical schemes and their administrators, where relevant, and parties collecting monies outstanding from you.

Protection of Personal Information Act *("POPIA")*
South Africa's data privacy legislation, the Protection of Personal Information Act No. 4 of 2013 ("POPIA"), requires all responsible parties who wish to process the personal information of a data subject to obtain consent to process this information for a specific purpose, if not already authorised or required to do so by law.

During the course of our engagement with you, we will be required to process certain personal information, either in terms of our engagement or following a legal obligation imposed on us. In order to continue providing you with a professional and personal service, we need your express consent to continue processing your personal data already in our possession or still to be collected from you or from another source.

Legislation compels the practice to provide certain information on accounts, including diagnostic information by means of ICD -10 Codes. Failure to disclose/submit the correct codes might lead to the claim being incorrectly paid or rejected by your medical scheme of funder. The Practice must also disclose ICD-10 codes on scripts, referral letters, requests for special diagnostic procedures or investigations. In the event of a third-party request for confidential information from the practice, and if there is doubt regarding the safety or confidentiality of these processes, the practice may insist on following the standard operating procedures allowed in legislation in order to ensure that the practice is comfortable with the manner in which the request is processed.

We hereby undertake that we will process your personal information in line with the conditions for lawful processing, as set out in POPIA, and as such we hereby commit to:

a) process your information lawfully and in a reasonable manner that does not infringe upon your privacy;
b) only process your personal information if the appropriate level of consent has been obtained to do so;
c) collect your personal information directly from yourself, unless otherwise allowed or required by way of referral;
d) only collect and process your information for the specified purpose, as agreed upon;
e) only retain your personal information for so long as is allowed or required; and
f) secure the integrity and confidentiality of your personal information by taking appropriate, reasonable technical and organisational measures to prevent the loss of, damage to or unauthorised destruction of your personal information and the unlawful access to or processing of your personal information.

A detailed list of your information held and processed by us is available for inspection and confirmation on request.

By signing this document, you hereby confirm that you understand why your personal information is needed by us and voluntarily consent to the use of this information by us in terms of POPIA. You in turn acknowledge that it is your responsibility to ensure the accuracy and completeness of the information provided to us. You further understand that you may request access to this information at any time and may request the correction or deletion thereof, where necessary.

Should you have any queries, please do not hesitate to contact our room, admin@capeortho.co.za

Acknowledgement of liability
I hereby acknowledge that I have read and understood the above and further understand that I am liable for the payment of this account, even if meant to be covered by a medical aid or any other third party. I understand that the practice reserves the right to charge interest on my outstanding account at Investec Bank Limited's current prime interest rate, from 60 days after the date of service. I further undertake to pay all legal costs, including attorney, own client costs, and collection fees incurred in respect of this account. I hereby undertake to give sufficient notice of any changes in my particulars. I confirm that I have been informed of the tariff charged by the practice and that I understand the information as provided to me.

Approval
I, the undersigned, agree to the terms as described above and voluntarily consent to the processing of such personal information as is needed by the responsible party, being Dr Johan Charilaou Incorporated.

Name and surname: _____

Signature: _____

Date: _____