**DATE: ____________________**

**HUSBAND / PARTNER:** ☐MR ☐DR ☐PROF / ☐MS ☐MRS

SURNAME: ____________________________

FULL NAME: ________________________________ KNOWN AS (NAME): _______________________________

ID NO: ______________________________________ DATE OF BIRTH: __________________________________

CELLPHONE: ________________________________ E-MAIL: ___________________________________________

TEL NO HOME: ______________________________ TEL No DURING TREATMENT: ______________________

TEL NO OFFICE: _____________________________ FAX:_____________________________________________

OCCUPATION: _______________________________ EMPLOYER NAME: ________________________________

WORK ADDRESS: ________________________________________________________________________________

**NUMBER OF CHILDREN:** _____ CURRENT RELATIONSHIP _____ PREVIOUS RELATIONSHIP

**MEDICAL AID:**

NAME: _________________________ PLAN TYPE: ______________________ DEPENDANCY CODE: __________

MAIN MEMBER: ________________________________ MEMBERSHIP NR: ____________________________

**RELIGION:** ________________________________________

**FEMALE / PARTNER:** ☐MS ☐MRS ☐DR ☐PROF / ☐MR

SURNAME: ____________________________

FULL NAME: ________________________________ KNOWN AS (NAME): _______________________________

ID NO: ______________________________________ DATE OF BIRTH: __________________________________

CELLPHONE: ________________________________ E-MAIL: ___________________________________________

TEL NO HOME: ______________________________ TEL No DURING TREATMENT: ______________________

TEL NO OFFICE: _____________________________ FAX:_____________________________________________

OCCUPATION: _______________________________ EMPLOYER NAME: ________________________________

WORK ADDRESS: ________________________________________________________________________________

**NUMBER OF CHILDREN:** _____ CURRENT RELATIONSHIP _____ PREVIOUS RELATIONSHIP

**MEDICAL AID:**

NAME: ________________________ PLAN TYPE: ______________________ DEPENDANCY CODE: __________

MAIN MEMBER: _________________________________ MEMBERSHIP NR: _____________________________

RELIGION: ______________________________________

**STREET ADDRESS**: ______________________________________________________________________________

CITY ____________________________ COUNTRY _________________________ POSTAL CODE: _____________

**POSTAL ADDRESS:** ______________________________________________________________________________

CITY ____________________________ COUNTRY _________________________ POSTAL CODE: _____________

**REFERRING PHYSICIAN**

NAME: ______________________________________ E-MAIL: _____________________________________

TEL NO: _____________________________________ FAX: ________________________________________

PHYSICAL ADDRESS: _______________________________________________________________________

WHOULD YOU LIKE AEVITAS TO SEND A REPORT TO YOUR REFERRING PHYSICIAN? ☐ YES ☐ NO

## HOW CAN AEVITAS BE OF ASSISTANCE?

☐ Struggling to fall pregnant ☐ IVF ☐ IUI

☐ Egg donation programme ☐ Male fertility ☐ Endometriosis

☐ PCOS ☐ Fibroids ☐ Reversal of sterilisation

☐ Gynaecological endoscopic surgery

☐ Fertility preservation (egg freezing, sperm freezing, embryo freezing, other)

☐ Other, please specify _____________________

**HOW DID YOU HEAR ABOUT US?**

Google Facebook Instagram LinkedIn

Website/directory other than Aevitas, please specify ____________________________________

Referral from doctor, If so, please specify Dr name _____________________________________

Referral from family or friend

Other, please specify ____________________________________________________________

- Rates of Aevitas clinic are in accordance with the guidelines of the Medical Council of S.A.
- This fee may not be the same as that which your medical aid is prepared to pay.
- **You are personally responsible for the settlement of your account, after which you may claim from medical aid.**
- I hereby certify that the above details given are correct.

PATIENT SIGNATURE: _______________________________ DATE:______________________________