Resilient Synergy
for optimal, adaptive health and wellness
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Resilient Synergy (PTY) LTD Registration no. 2019 / 176190 / 07

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FILE NO: _____

PATIENT REGISTRATION FORM

Strictly Confidential & POPIA Compliant

1. PATIENT DEMOGRAPHICS

Surname: _____ **First Name(s):** _____

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr **Marital Status:** _____

ID / Pass No: _____ **Date of Birth:** _____

Age: _____ **Gender / Sex:** ☐ Male ☐ Female ☐ Other

Cell/WhatsApp: _____ **Alternative Tel:** _____

Email Address: _____

Home Language: _____ **Occupation:** _____

2. MEDICAL AID DETAILS

Leave blank if patient is private/cash.

Medical Scheme: _____ **Plan / Option:** _____

Medical Aid No: _____ **Dependant Code:** _____

Principal Member: _____

Principal Member ID: _____

3. PERSON RESPONSIBLE FOR ACCOUNT

Complete only if different from the patient (e.g. parent, guardian, or guarantor).

Full Name: _____ **ID Number:** _____

Cell Number: _____ **Alternative Tel:** _____

Home Address: _____

Postal Address: _____ **Postal Code:** _____

Employer Name: _____ **Work Telephone:** _____

4. EMERGENCY CONTACT & NEXT OF KIN

Full Name: _____ **Relationship:** _____

Contact No: _____ **Alternative Tel:** _____

5. REFERRAL SOURCE & FAMILY LINKS

☐ Word of Mouth / Friend ☐ Internet Search ☐ Walk-in

Referred by Doctor: _____

Family Grouping: If other family members attend this practice, please note names for file linking:

6. TERMS, CONDITIONS & POPIA CONSENT

- **Financial Liability:** This account remains the final responsibility of the patient/guarantor until settled fully. Regular follow-ups by the scheme member with their medical aid may be required to ensure prompt payment [cite: 35]. If your medical scheme does not settle the account in full, you remain strictly liable for the balance [cite: 36].
- **POPIA & Data Sharing:** I grant explicit consent to the practice to process and share my Personal Information with selected healthcare providers, medical schemes, administrators, and contracted third parties necessary for the provision of continuous clinical services [cite: 38].
- **Digital Communication:** I agree that Personal Information provided will be used to complete tasks related to my medical care [cite: 39]. This includes communicating confidential clinical information, results, or scripts using secure email or WhatsApp chats for care and urgent medical follow-up [cite: 40]. Confidentiality and compliance are protected via our POPIA policy [cite: 41].
- **Verification:** I understand and accept the above conditions and verify that all personal, billing, and clinical details provided on this form are true and correct [cite: 37].

_____ _____

Signature of Patient / Main Member / Legal Guardian **Date (DD / MM / YYYY)**