Dr. Sarel Botha
Maxillofacial & Oral Surgeon
MBChB (Pret) | BChD (Pret) | Dip Odont (Pret) | MBA (Regent) | MChD (MFOS)(Pret) | FCMFOS (SA) FIFHNOS

Dr BL van Niekerk
Maxillofacial & Oral Surgeon
BChD, MBChB, PGDipDent(OralSurg), MChD(MFOS), FCMFOS(SA)

Practice No. 0557846

012 346 6032 012 346 7549 084 799 1111 reception@sarelbotha.com | admin@sarelbotha.com | accounts@sarelbotha.com

Medical Suite 6, Cintocare Hospital Level 4, 175 Frikkie de Beer St, Menlyn Maine, Pretoria, 0181 www.sarelbotha.com | Dr Sarel JP Botha

PERSONAL INFORMATION CONSENT FROM

Full name of Patient _____

(All patients from the age of 18 years and up must give consent)

Full Name of Parent/Guardian _____

I do herby acknowledge, consent and agree to all of the following terms and conditions:

- I give my consent in giving the relevant personal information to the hospital for theatre bookings if necessary.
- I give my consent in giving my relevant personal information to the offices of the anesthetist or any doctor who will assist Dr Botha in theatre if necessary.
- I give my consent to the accounts department of Dr SJP Botha to follow up on my Medical Aid/Medical insurance regarding PMB payments.
- I give my consent to the Practice of Dr SJP Botha to give the relevant personal information to any specialist that Dr SJP Botha refers me to.
- I give my consent that the Practice of Dr SJP Botha may send a report to the Doctor that referred me to Dr Botha.
- I give my consent that the practice of Dr Botha send my relevant personal information to the pathologist or Radiologist if necessary.
- I give my consent that the Practice of Dr SJP Botha may give a medical certificate to my employer if necessary.
- I give my consent that the Practice of Dr SJP Botha may give the hospital staff, pharmacy or to myself a prescription if necessary.
- I give my consent that the Practice of Dr SJP Botha may use my relevant personal information to the legal company Duvesco should my account be outstanding for 60 days or longer.
- I give my consent that the ICD10 codes for my procedure may be given to the medical aid /medical insurance, anesthetist, hospital or assisting Doctor for authorization.
- I give consent/do not give consent that _____ (Full name) _____ (ID no), my next of kin may be given information regarding my treatment in hospital/out of hospital.
- I give consent that my personal information may be kept secure by the relevant departments of Dr SJP Botha for the use of accounts, clinical notes, pans/scan and diary on the relevant computers.
- I give consent that my mobile, work number or e-mail address may be used for communication regarding my health, accounts or appointments by the Practice of Dr SJP Botha.

_____ _____
Signature of Patient Signature of Parent/Guardian

_____ _____
ID no of Patient ID no of Parent/Guardian

_____
Date