primecure health
leadingintegratedhealthcare

PRINCIPAL MEMBER DETAILS		PATIENT DETAILS	
Surname		Surname	
Name		Name	
Initials		Initials	
Dependent No		Dependent No	
Occupation		Occupation	
Age		Age	
I. D. No		I. D. No	
Tel. No Work / Home		Tel. No Work / Home	
Cell		Cell	
Medical Aid No		Medical Aid No	
Medical Aid Name		Medical Aid Name	
Medical Aid Option Name		Medical Aid Option Name	

Tested by:_____

OPTOMETRIST (Name & Signature)

Declaration by Patient:

I the undersigned, _____ hereby confirm that:

1) I attended the consultation as dated

2) I was shown the specified range of frames applicable to my optical benefit

3) I am satisfied with the script as determined during the consultation

4) I understand that if I choose a frame or other exstras outside the standard benefit, that I am personally liable for the applicable co-payment of R_____

Signature:_____

Date:_____

Practice name	
Practice number	
Fax number	
Authorisation no	
Date of consultation	

PRESENT RX:	Sph	Cyl	Axis	Δ	Base	Add	VA
R							
L							

UNAIDED VA:				
DISTANCE:	R		NEAR:	R
	L			L

NEW RX:	Sph	Cyl	Axis	Δ	Base	Add	VA
R							
L							

CR39			GLASS
SV	BF	TF	MF
PROX			
P.D. DIST.	P.D.NEAR	SEG. HT. R	SEG. HT. L
TINT	COAT	OTHER	BLANK SIZE

FRAME DETAILS	MOD		COL		COST	R

BENEFIT AUTHORISED:

EYE TEST		R
SINGLE VISION PACKAGE		R
BIFOCAL PACKAGE		R
AUTHORISATION NO		

Universal Signs 012 329 1724