PATIENT DETAIL

PATIENT NAME: ....SURNAME:.....TITLE:.....

ID NUMBER: ..... DATE OF BIRTH: .....

HOMEADDRESS:.....

.....

.....

POSTAL ADDRESS: .....

.....POSTAL CODE: .....

CELL NO: ..... WORK NO: .....

HOME NO:.....FAX NO: ....

EMAIL ADDRESS: ....

PERSON RESPONSIBLE FOR ACCOUNT

NAME:.....SURNAME:.....TITLE:.....

ID NUMBER:..... DATE OF BIRTH:.....

POSTAL ADDRESS: .....

.....POSTAL CODE: .....

CELL NO: .....WORK NO: .....

HOME NUMBER: ..... FAX NO: .....

EMAIL ADDRESS: .....REFERRED BY:.....

NAME OF MEDICAL AID:.....MEDICAL AID NO: .....

PLEASE NOTE: ***CONTRACTED OUT OF MEDICAL AID***

1 .Our treatment is based on your dental health needs and not on your medical aid cover.

2. It is important you understand and consent to both the treatment plan and the estimated cost of treatment.

3. It is your right to accept or decline our recommended treatment plan. If you reject or delay recommended treatment, you do so at your own risk.

4. You are requested to sign acceptance of our treatment plan and cost estimate. If clinical conditions require change in treatment, full details and cost will be provided before proceeding with modified treatment.

5. All patients will be furnished with an account for services rendered. Please review and understand what treatment was provided.

6. Patients are responsible for payment of accounts *on the day off treatment*, this practice do not run accounts.

7. Some or all of our fees may not be based on the National Health Reference Price List (NHRPL).Please consult medical scheme to determine their reimbursement policies for dental services.

8. Patients are encouraged to submit cost estimates to their schemes before proceeding with treatment so that they may budget accordingly. P.T.O.

9. Dental technicians fees and costs of components may be payable in advance. A cost estimate will be given.

10. We accept most Major credit cards but regret not AMERICAN EXPRESS OR DINERS CARD.

11. In the event of failure to settle the account, I agree to be liable for all legal costs calculated on the scale as between attorney and own client including all collection commission. Interest on overdue accounts will be charged at the statutory tariff.

- **MEDICAL HISTORY**

• Have you had Rheumatic Fever?	YES	NO
• Do you suffer from Hayfever,Eczema	YES	NO
• Are you allergic to any drugs or medicines?	YES	NO
• Do you have any chest conditions i.e.Asthma ?	YES	NO
• Do you suffer from high blood pressure?	YES	NO
• Do you have, or have you had abnormal bleeding after,surgery or injury?	YES	NO
• Do you suffer from epilepsy?	YES	NO
• Are you pregnant ?	YES	NO
• Do you smoke?	YES	NO
• Have you ever had joint replacement surgery ?	YES	NO
• Have you undergone any surgery in past 2 years?	YES	NO
• Do you take any medicines regulary ?	YES	NO
• Are you diabetic?	YES	NO
• Any heart conditions,(stent) ?	YES	NO
• Are you HIV Positive?	YES	NO

If you are not sure of any of the questions, or if your medical circumstances change, please tell your dentist.

Would you like to be reminded of your Dental check up? 6months 12 months 18months

Would you like to be reminded of your Dental cleaning appt.? " " "

Signature.....