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All information will be treated in the strictest of confidence.

TITLE: ______________ FIRST NAMES: ______________________________

SURNAME: ______________________ ID NUMBER/DATE OF BIRTH ______________________

TEL (H): ______________ CELL: ________________ E-MAIL: ______________________

EMPLOYER: ______________________________ TEL (W): ______________________

PRINCIPAL MEMBER OF MEDICAL AID: /(PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT):

FULL NAME: ____________________________ ID NUMBER ______________________

MEDICAL AID: __________________________ MEMBERSHIP NO: ______________________

TEL (H): ______________ CELL: ________________ E-MAIL: ______________________

EMPLOYER: ______________________________ TEL (W): ______________________

POSTAL ADDRESS: ____ CODE: __________

RESIDENTIAL ADDRESS: ____ CODE: __________

WHO REFERRED YOU TO THIS PRACTICE: ______________________________________.

MEDICAL HISTORY OF PATIENT (indicate with a tick)

__ALLERGY (specify) ____

__HEART TROUBLE	__HIGH BLOOD PRESSURE	__ANAEMIA
__CHEST PROBLEMS	__RHEUMATIC FEVER	__DIABETES
__ABNORMAL BLEEDING	__ASTHMA	__IMMUNE DISEASE
__EPILEPSY	__HEPATITUS	__ARTIFICIAL BODY PARTS e.g. .Hip,etc.

WHAT MEDICATION ARE YOU ON? ____

WOULD YOU LIKE TO HAVE REGULAR CHECK-UPS (RECALL)? ______________________________

PLEASE NOTE:
This is a private practice and has no contracts with any medical aids or government health schemes.
This practice does not limit itself to the NHRPL fee or any other medical aid fee structures.

Payment is always due after each appointment.

On signing this you accept responsibility for payment of all dental services rendered
Interest is chargeable on overdue accounts. This is agreed at 1.25% per month on balances over 30days.
You are responsible for all legal fees should the account be handed over for collection.
Please submit your paid up statement to your medical aid for reimbursement.

I ACCEPT AND UNDERSTAND THE CONDITIONS HEREIN.

PATIENT ____________________________ DATE ____________________________