PATIENT INFO

Dr Isabel Bronkhorst
DENTIST
BChD (Pret); PDD Orthodontics (UWC)

MAIN MEMBER (PLEASE WRITE IN BLOCK CAPITALS)

Nr:

Details of person responsible for paying account:

Surname and Initials: _____

First Names: _____

Identity Number: _____

Street Address: _____

_____

Postal Address: _____

Home Tel: _____

Cell Number: _____ **ALTERNATIVE NUMBER:** _____

E-mail: _____ **ALTERNATIVE E-MAIL:** _____

Medical Fund & Plan:

Medical Fund: _____ Medical Aid Number: _____

Address to which account should be sent: Postal Address: _____ Street Address _____

Occupation: _____

Employer and Business Address: _____

Work Tel: _____

Patient Details (PLEASE WRITE IN BLOCK CAPITALS)

PATIENT (FIRST NAMES)	BIRTH DATE

By whom were you reffed: _____

Name of House Medical Doctor: _____

Name of Dentist: _____

MEDICAL HISTORY

Clearly Mark with an X:

Any heart conditions [Y][N] Rheumatic fever [Y][N] High Blood Pressure [Y][N] Any Blood Clotting Disorder [Y][N] Any anti-coagulant therapy [Y][N] History of diabetes [Y][N] History of porphyria [Y][N] Asthma [Y][N] History of TB [Y][N] HIV/AIDS [Y][N] Any lung Condition [Y][N] Liver disease [Y][N] Epilepsy Cortisone therapy [Y][N] Multiple sclerosis [Y][N] Allergies [Y][N] Please Specify:

Do you wear contact lenses? [Y][N]

Are you a member of medic alert [Y][N] Do you take any medication ? [Y][N]

Please Specify:

Female Patients (NB For growth assessment)

Are you Pregnant? [Y][N] Are you using contraceptive? [Y][N] Have you started menstruating? [Y][N]

PAYING OF ACCOUNTS

Most medical aids do not pay our professional fees in full. As a result there is likely to be a co-payement or excess on your account. This payment, which you are responsible for, may only become apparent after the claim has been submitted. Being a member of a medical aid and getting pre-authorization does not guarantee payment by the medical aid. You as Guarantor are responsible for settling the treatment fees in full. Our Terms are cash or strictly 30 (thirty) day. **Interest will be charged on overdue accounts**. Accounts older than 60 days will be handed over to recovery and hereby agree to all legal costs involved. Terms and Conditions arranged on Request. You Hereby choose as your domicilium citandi ret executandi this address and have to inform us in writing, should there be any changes. Please let us know should you require any clarifications on your obligations.

Mark means of payment you prefer:

CASH ○ **CREDIT CARD** ○
DEBIT CARD ○ **EFT** ○

SIGNATURE: _____ DATE _____

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