

Welcome to our Dental Practice. Please make yourself comfortable take a few minutes to complete both sides of this consent form. Please read and complete ALL fields.

##### PATIENT DETAILS MEDICAL AID C/O

Title (Mr /Mrs /Ms /Miss) …………………………………………………………

Surname: …………………………………………………………

First Name: …………………………………………………………

I.D No (adults) / Date of birth (kids) : …….……………………………………….

Address: …………………………………………………………………………. (**NOT** P. O BOX)

…………………………………………………………………………

Tel No. Home: ……………………………………………………………….. Work: …………………………

Cell (For SMS Reminders) ………………………………………………………

Email (For Reminders & Statements) ………………………………………….

Occupation (Company) …………………………………………………………….

###### MEDICAL HISTORY

Name of medical doctor …………………………………………………………… Tel No: ………………………..

Have you been treated for: (Tick where applicable)

HEART TROUBLE / MURMUR [ ] HIGH BLOOD PRESSURE [ ]

RHEUMATIC FEVER [ ] ASTHMA [ ]

**DIABETES [ ] EPILEPSY [ ]**

**DIGESTIVE PROBLEMS [ ] T.B [ ]**

**KIDNEY PROBLEMS [ ] JAUNDICE / HEPATITIS [ ]**

**OTHER ILLNESS [ ]**  Please specify ………………………………………….

Are you subject to **prolonged bleeding?** ……………………………………………………..

Are you **allergic to penicillin** or any other drugs? ………………………………………………………

Are you taking any **medication** at the moment? ………………………………………………………

Are you pregnant or suspicious of **pregnancy?** ………………………………………………………

How much do you **smoke** per day? ………………………………………………………

How much **alcohol** do you drink per day? ………………………………………………………

When was your **last visit to the dentis**t? ………………………………………………………

**HOW DID YOU HEAR ABOUT KROMBOOM DENTAL CENTRE?** (Tick where applicable)

Through a Friend / Relative [ ] Name (Optional)……………………… TV/ Radio Advert [ ]

Another Doctor / Dentist [ ] Advert (Vision Advertiser ) [ ]

Internet Search / Website [ ] Advert (Peoples Choice / Tatler) [ ]

Yellow / White Pages [ ] Advert (DVD Cover Rondebosch [ ]

Promotional Leaflet [ ] Advert (DVD Cover Pinelands) [ ] Stumbled Upon [ ] Other, specify ……………………..

**PLEASE TURN OVER**

**PERSON RESPONSIBLE FOR ACCOUNT/ MAIN MEMBER**

First Name & Surname: ………………………………………………..........................

I.D No: ………………………………………………………………………..

Home Address: ………………………………………………………………………...

………………………………………………………………………...

Work Address & Company Name: …………………………………………………….

…….………………………………………..……….

Tel No: Home: ………………………………………………………………. Work: ………………………………………………….

Email (For Reminders & Statements) …………………………………………………

**NEXT OF KIN (NOT LIVING WITH YOU)**

First Name & Surname: ………………………………………………………………

Address: ……………………………………………………………….

……………………………………………………………….

Tel No: Home: ………………………………………………. ……………….… Work: ………………………………………………….

MEDICAL AID DETAILS

**Name of Medical aid/ scheme:** ……………………………………………………. **Medical Aid No:** ……..…………………………..

**Medical Aid Plan / Option:** ……………………………………………………… **Dependant code (00 or 01 or 02)** ……………………

**PLEASE READ CAREFULLY AND SIGN BELOW (VERY IMPORTANT INFORMATION):**

I consent to be treated by **DR. S. KHAN / DR. S. JONES / DR. N. NATHA / DR. A. MOHAMED / DR. W. PALMER / DR. F .PARKER / DR. A. ALLIE/ L. PATEL / Z. JACOBS / A. ALBERTUS / L. DAVIDSON / T. OCTOBER & ASSOCIATES**

Signature: …………………………………………

Our Practice Policy Involving Medical Aids: This practice charges fees recommended by the Medical Aids **EXCEPT FOR IMPLANTS, CROWN & BRIDGEWORK AND SURGICAL EXTRACTIONS WHERE A SURCHARGE WILL APPLY**. Please do not hesitate to enquire about our fees prior to consultation. Your account has to be settled on the day treatment is rendered and you will be offered a 5% settlement discount. You will be issued with a full statement and receipt for the submission to you medical aid for reimbursement into your account.

I certify that all the information I have supplied is correct and I understand that I am personally responsible for settlement of the account even though I have **medical aid insurance.** I accept responsibility for all charges and the charging of interest on all overdue accounts at 2% p.m.

Signature: ……………………………………… Date ……………………………

Unfortunately due to the high running costs and the fact that many patients fail to attend appointments without notice, we have to implement a new policy whereby a fee of R150 per half hour will be charged if an appointment is not kept or cancelled too late. Your co-operation in this matter is much appreciated.

In compliance with the CPA, dental treatment is guaranteed for 6 months from the date of placement.

Terms and Conditions apply.

**THE INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL**

**For more information about us and our services visit our website:**

**W W W . K R O M B O O M D E N T A L . C O . Z A**

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