

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 PRIVATE

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 dentist**? ………………………………………………………

**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**

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: ………………………………………………….

Name and address of parents and / guardian (if under 18 yrs old)

…………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………

**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: ……………………………….

Please note that we do not have an account system. All accounts to be settled on the day of treatment by cash, debit, credit or Edcon cards. We are also affiliated to Dental Finance who can finance your dental procedures. We DO NOT accept cheques OR EFT Payments. The account has to be settled when the treatment is rendered. You will be offered a 12% discount for cash, 10% discount for debit or credit card and NO discount for Edcon card payments. If for any reason, the account is not settled or a 50%deposit is not paid on the day impressions are taken for laboratory work, by the close of business on the day of treatment FULL price applies. The discount will be forfeited.

Due to increasing bad debt, this practice is affiliated to Credit Collect (Pty) Ltd, a credit rating company. All costs for handovers to Credit Collect will be borne by the patient. All accounts not paid within a week of treatment will be charged in full, admin fees charged and automatically handed over for collection. It is the patients’ responsibility to make sure the account is settled as it will be handed over automatically without warning if not settled in full within a week of treatment.

I certify that all the information I have supplied is correct and I understand that **I am personally responsible for settlement of the account.** If in the event, the account is not settled in full, I accept responsibility and charging of admin fees and 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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