Registration and Health History

Main Member/Responsible for Account

☐ Private ☐Medical Aid

Title: **Name:**		**Surname:**	**Nickname:**
ID No:		**DOB:**	
Street Address:			
			Postal Code:
Tel Home:	**Cell:**	**E-mail:**	
Occupation:		**Employer:**	**Work:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Medical aid:		**MA Number:**	**MA Plan:**

INFORMATION OF SPOUSE

Title: **Name:**		**Surname:**	**Nickname:**
ID No:		**DOB:**	
Street Address:			
			Postal Code:
Tel Home:	**Cell:**	**E-mail:**	
Occupation:		**Employer:**	**Work:**

INFORMATION OF MINOR DEPENDANTS

Name:	**Surname:**	**DOB/ID No.**
Name:	**Surname:**	**DOB/ID No.**

INFORMATION OF ADULT DEPENDANT

Title: **Name:**		**Surname:**	**Nickname:**
ID No:		**DOB:**	
Street Address:			
			Postal Code:
Tel Home:	**Cell:**	**E-mail:**	

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Name:	**Surname:**
Cell:	**E-mail:**
Address:	**Relation to patient: example (father/Mother) :**

Whom may we thank for referring you to our practice?

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you.		
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

QUESTIONAIRE

Do you normally require antibiotic treatment before dental treatment?	☐ Yes	☐ No
Have you had any abnormal reactions to local or general aesthesis?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Are you pregnant: How many weeks? Breastfeeding?	☐ Yes	☐ No
Have you had any of the following conditions:		
Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Bone disease Inc. Osteoporosis	☐ Yes	☐ No
Radiation therapy	☐ Yes	☐ No
High or low blood pressure	☐ Yes	☐ No
Prosthetic Imp E.g. Artificial Hip	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No
Have you recently been on Cortisone therapy	☐ Yes	☐ No
Do you take Fosamax or received any Radio Therapy	☐ Yes	☐ No
Do you use any medication for blood clotting	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions, terms and acknowledge that Dental Co don`t charge medical aid tariffs - I agree to pay all charges for which I may be legally responsible including, medical aid, co-payments, and non-covered Codes. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Dental Co . I understand and agree this document will remain in effect for all future visits to Dental Co , unless specifically rescinded in writing by me.

We need the above information so that we can help obtain the dental benefits you are eligible for. This may require submitting the Doctor's treatment plan to the medical aid for a pre-determination of benefits, or authorization by phone and internet of which a fee of R250 will be charged - Dental Co can ***NEVER*** *guarantee payment by your Medical Aid. The Medical Aid's contract is with you and your employer, and is the members responsibility to obtain reasons for none payment.*

I understand and agree that, regardless of my Medical Aid Benefits, I am ultimately responsible for the balance on my account for any services rendered. I certify the information on the Patient Information Form is true and correct to the best of my knowledge. I will notify Dental Co of any changes in my health status or any changes in the above information.

I also take note of the Administration fee that will be charged for each /claim that will be submitted to my medical aid.

Signature of Patient/Guardian: _____ Date: _____