NB: I hereby acknowledge and agree that all the details given on this form are correct as at ……..20…

EDEN DENTAL CENTRE

1. MAIN MEMBER DETAILS

ACC NUMBER:

SURNAME (main member)	TITLE:
FULL NAMES (main member)	
ID NUMBER (main member)	
TELEPHONE No: (H) (main member)	
TELEPHONE No: (W) (main member)	
CELLPHONE No: (main member)	
EMAIL ADDRESS (main member)	
RESIDENTIAL ADDRESS	
	CODE:
POSTAL ADDRESS	P O BOX:
	CODE:
	IF SELF EMPLOYED PLEASE GIVE FULL NAME OF COMPANY
EMPLOYER'S NAME AND ADDRESS	
OCCUPATION	
2. SPOUSE'S DETAILS	NAME: TITLE:
CONTACT NUMBERS	(W): CELL:
SPOUSE'S I D NUMBER	
EMAIL ADDRESS:	

3. MEDICAL AID DETAILS :

OR PRIVATE: X

MEDICAL AID NAME		
NUMBER		
OPTION		
DEPENDANT CODE (MAIN MEMBER)		

4. PERSONAL REFERENCES (PLEASE NOTE THIS IMPORTANT SECTION MUST BE COMPLETED)

FAMILY MEMBER OR FRIEND

1:……. TEL:…….

2:…… TEL:…….

5. DEPENDANT DETAILS:

NAME	DATE OF BIRTH	DEPENDANT CODE ON M/AID
1.		
2.		
3.		
4.		

TURN PAGE OVER

6.MEDICAL HISTORY (PLEASE NOTE THIS IMPORTANT SECTION MUST BE COMPLETED)

CONDITIONS:	MAIN MEMBER		DEPENDANT		DEPENDANT		DEPENDANT		DEPENDANT	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
RHEUMATIC FEVER										
HEART CONDITION										
BLEEDING DISORDER										
STROKE										
LUNG DISORDER OR ASTHMA										
HEPATITIS/ JAUNDICE										
HIV/AIDS										
CORTISONE TREATMENT										
EPILEPSY										
HIGH OR LOW BLOOD PRESSURE										
PORPHYRIA										
DIABETES										

PLEASE LIST ANY MEDICATION YOU ARE TAKING NOW:

…….

DO YOU HAVE ANY ALLERGIES? YES/NO (E.G. PENICILLIN, SULPHUR ETC):……

ARE YOU PREGNANT (IF YES, HOW MANY MONTHS)?…… ARE YOU TAKING ORAL CONTRACEPTIVES: YES/NO

Please note the person filling out this patient form, whether you are the principal member, an adult dependant or legal guardian, must read and sign the following:

MEDICAL AID PATIENTS: (Main Member or adult dependant or legal guardian)

(The patient remains liable for his/her account until it is settled in full. You are advised to determine the extent of your dental benefits prior to commencement of treatment as well as scheme rules regarding dental benefits.)

I,……, am authorized to sign this form on behalf of the principal member. Furthermore, I, hereby agree to pay all debt recovery fees including collection and tracing costs in the event of the payment of any account not being received timeously.

I, the undersigned, accept responsibility for the cost incurred for professional services to be rendered. In the event of failure to settle my account within 14 days of provision of the services, I will be liable for interest and all legal costs calculated on the scale as between attorney and own client including all collection commission and tracing fees. I choose as my Domicilium Citandi Et Exectandi the residential address as set out above. The creditor or its nominated representative may access any of my information available or disclose my failure to pay or erratic payments to any credit bureau or third party, ITC and Medicheck, without incurring any liability therefor.

SIGNATURE

……DATE……

PRIVATE PATIENTS:

I, the undersigned, accept responsibility for the cost incurred for professional services to be rendered. I understand that the full amount will be payable after treatment and that the practice does not run accounts. I understand that payment methods are cash, credit or debit cards. I furthermore understand that the practice has secure access to the internet for electronic transfers on site should I need to do an eft.

SIGNATURE

……DATE……