Dentist Keshrina

Dental perfection. Creating your beautiful smile.

PATIENT DETAILS

Surname	Mr./Mrs./Miss.	Marital status
ID number	First Names	
Date of birth	Age	No. of dependents
Occupation	Cell No.	Tel No.

PERSON RESPONSIBLE FOR ACCOUNT

Full Name	ID No.
Home address	Cell No.
Code	Tel: (H)
Postal address	Postal code
Email address	Fax No.
Employer	Tel: (W)

MEDICAL AID

Fund	No.
Member's name	Dependent code

NEXT OF KIN (not residing with you)

Name	Relationship
Address	Tel:

REFERRED BY

Name	
Address	Tel:

MEDICAL HISTORY

Please tick appropriate answer	Yes	No
Previous admissions to hospital …………		
Previous anesthetic …………		
Present medications …………		
Heart problems …………		
High blood pressure …………		
Rheumatic fever …………		
Epilepsy …………		
Lung problems / Asthma …………		
Hepatitis – Jaundice …………		
Diabetes …………		
Stomach ulcers …………		
Bleeding tendency …………		
Allergies …………		
Kidney problems …………		
Cortisone therapy …………		
Any family disease …………		
Ladies - pregnant …………		
Smoker …………		

Strictly 30 days. I acknowledge that I am personally responsible for the settlement of this account in full. I agree to be liable for all legal costs and collection costs arising in the event of failure to settle my account in full.

Signed: ………………………………………… Date: ………………………