Crown Dental Studio

PATIENT INFORMATION SHEET

****PLEASE ENSURE ALL FIELDS ARE COMPLETED***

PATIENT DETAILS:

Name:	**Surname:**
Date of Birth:	**Telephone Number: ( )**
Identity Number:	**Mobile Number:**

PERSON RESPONSIBLE FOR ACCOUNT:

Full Name:	**Identity Number:**
Residential Address:	**Postal Address:**
Telephone Number: ( )	**Mobile Number:**
Name of Employer:	**Work Address:**
Occupation:	**E-mail Address:**

MEDICAL AID DETAILS:

Medical Aid Name:	**Member Number:**
Option/Plan:	**Dependant Code:**
Occupation:	**E-mail Address:**

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MEDICAL HISTORY:

Present Conditions if any:	Surgical procedures done in the last 5 years:
Medication (chronic, day-to-day, self-medication):	Allergies:
Pregnancy:	Other:

NEXT OF KIN DETAILS:

Full Name:	Contact Number:
Relationship to Patient:	Address:
E-mail Address:	

I HAVE BEEN FULLY INFORMED OF THE FEES AND THE TREATMENTS AVAILABLE, AND THE NECESSITY FOR FOLLOW-UP CARE. I HAVE HAD AN OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE IN CONNECTION WITH THE TREATMENT AND FEES AND TO DISCUSS MY CONCERNS WITH CROWN DENTAL AND THEIR STAFF.

BY SIGNING THIS DOCUMENT, I AUTHORIZE CROWN DENTAL AND /OR HIS/HER ASSOCIATES TO RENDER ANY SERVICES DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF MY DENTAL CONDITION, INCLUDING THE PRESCRIBING AND ADMINISTRATION OF ANY MEDICALLY NECESSARY ANESTHETIC AGENTS AND/OR MEDICATIONS. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS.

I, ____ UNDERSTAND THE FOLLOWING MEDICAL AID MEMBERSHIP AND OTHER MEDICAL INSURANCE IS A PERSONAL CONTRACT BETWEEN THE MEMBER AND THE INSURANCE COMPANY. ALL CLAIMS NOT SETTLED BY MY MEDICAL INSURER WITHIN 60 (SIXTY) DAYS IS REQUIRED TO BE SETTLED BY THE PERSON RESPONSIBLE FOR THE ACCOUNT. IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE THEIR MEDICAL AID CONTAINS SUFFICIENT FUNDS AND BENEFITS AT THE TIME OF THE CLAIM BEING PROCESSED.

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I ACKNOWLEDGE, UNDERSTAND AND IRREVOCABLY AGREE TO THE TERMS AND CONDITIONS OF THIS PRACTICE (a copy can be made available upon written request). YOU WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS.

I HEREBY GIVE CONSENT FOR DENTAL TREATMENT FOR MY CHILD/ MYSELF, NAMELY:

____

AND LEAVE THE NATURE AND EXTENT OF THE TREATMENT TO THE DISCRETION OF THE DENTAL SURGEON/ORAL HYGIENIST.

I UNDERSTAND THAT ALL RECORDS REMAIN THE PROPERTY OF CROWN DENTAL STUDIO (PTY) LTD AND THAT THEY MAY BE USED FOR ACADEMIC AND OR SOCIAL MEDIA PURPOSES. FURTHER I FULLY REALISE THAT TREATMENT WILL BE CARRIED OUT BY PRACTITIONERS AND THAT I WILL BE RESPONSIBLE FOR FULL PAYMENT PRIOR TO TREATMENTS AND THAT I AM LIABLE FOR ANY FEES UPON COMMENCEMENT OF ANY SUCH TREATMENT.

<u>PATIENT PARTICULARS:</u>

FULL LEGAL NAME: ___________________________________

IDENTITY NUMBER: ___________________________________

ADDRESS: ____

____

____

CONTACT NUMBER: ______________________________________

EMAIL ADDRESS: ____

Accepted and Signed at __________________ on this _____ day of __________________ 20______

in the presence of the undersigned witnesses

____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

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Witnesses:

1. ___________________________________
   NAME:
   CONTACT NUMBER:
2. ___________________________________
   NAME:
   CONTACT NUMBER: