Dr. Simoné
DENTIST

PATIENT DETAILS:

Surname:	First Names:
Date of Birth:	ID No:
Occupation:	Home Language:
Tel (H):	Tel (B):
Cell:	E-mail:
Dependent Code:	

MAIN MEMBER OF MEDICAL AID / PERSON RESPONIBLE FOR ACCOUNT:

Surname:	First Names:
ID Number:	
Home Address:	
	Code:
Postal address:	
	Code:
Employer:	Occupation:
Tel (H):	Tel (B):
Cell:	E-mail:

MEDICAL AID DETAILS:

Medical aid Name:	
Plan:	Number:

NEAREST FAMILY/FRIEND:

Name:	Cell:

MEDICAL HISTORY: Mark appropriate box with **x**

Heart Disease		Vascular Disease	
Rheumatic fever		High blood pressure	
Any Prosthesis? Where?		Stroke	
Porphyria		Blood Clotting problems	
Arthritis		High Colesterol	
Sinus problems		Asthma	
Tuberculosis		Diabetic	
Cancer		Stomach/intestinal problems	
Have you positively been exposed to HIV/AIDS?		Organ transplants	
Kidney problems		Hormonal Problems	
Jaundice or Liver Problems		Epilepsy	
Anaemia		Do you smoke? How many per day?	
Have you taken cortisone in the last 2 years?		Depression	

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Do you have any allergies? Which?

Do you take any chronic medication? Which?

Female Patients: Are you pregnant?	How many months?

MEDICAL AID PATIENTS

- Should you wish for us to claim for you from your medical aid, a submission fee will be charged. This amount will be calculated at 6% of your account for that day of treatment and will be required to be paid in full directly after your appointment.
- Your medical aid will **NOT** cover the submission fee.
- Treatment will be submitted to your medical aid on your medical aid's scheme tariff. However we cannot guarantee what your medical aid will pay per claim and cannot be held liable for non-payment by your medical aid.
- Please be familiar with your medical aid benefits. It is the member's responsibility to know whether authorisation or motivation is required. We will be happy to assist you where necessary. The practice will not be held liable for non-payment from your medical aid due to lack of authorisation or motivation.
- If a claim is not paid in full by your medical aid, it is your responsibility to pay the outstanding amount.
- If you would prefer not to pay the submission fee, then full payment of your account will be required directly after your appointment.

PRIVATE PATIENTS

- All treatment should be paid in full directly after the procedure.
- No payment agreements or down payments will be accepted
- For large procedures, a down payment may be required.

If a claim is not paid in full by your medical aid, it is your responsibility to pay the outstanding amount

Name:_____Sign:_____Date: _____