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Associates



**THE HOME OF
BIOLOGICAL DENTISTRY**
Beyond your physical health

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Dentistry

YOU ARE WELCOME TO OUR DENTAL PRACTICE

It is an honour for us to enter into a professional relationship with you. We are proud of being able to offer you a new relaxed experience at the dentist. Our ethics, professional experience and our high standards have reassured thousands of patients.

1. What Is The Main Reason Of Your Visit?

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2. How did you hear about our dental surgery or who referred you?

.....Tel. No:

3. Details of Patient (Please use block letters)

Title: Mr/Mrs/Miss/Dr Surname:..... Given name: Nick name:

Date of Birth: ID/Passport:
Cell phone No: Other No:
E-mail Address:
Home Address:Code:
Occupation: Employer:

4. Medical History

Are you presently in pain?	N / Y	Hip/disk/Knee replacement?	N / Y
Any medical concern?	N / Y	Malnutrition: obesity/Anorexia?	N / Y
Any memory problems?	N / Y	Osteoporosis?	N / Y
History of Cancer?	N / Y	Anaemia & Blood clotting disorders	N / Y
Family History-Cancer/Metastatic	N / Y	Receiving Hyperbaric Treatments	N / Y
Any Autoimmune disease?	N / Y	Blood Type?	
Any heart condition?	N / Y	Do your gums bleed occasionally?	N / Y
Are you diabetic?	N / Y	Are your teeth chipped or uneven?	N / Y
Are you on any medication?	N / Y	Do you grind/clench your teeth?	N / Y
Do you get occasional headaches?	N / Y	Do you floss every day?	N / Y
Do you use painkillers?	N / Y	Do you like the colour of your teeth?	N / Y
Do you have any Allergies?	N / Y	Do you like your smile?	N / Y
Any hormone therapy?	N / Y	Covid vaccination? N / Y Brand Name:	
Thyroid treatment	N / Y	Are you on a "health path"?	N / Y
Infection / trauma?	N / Y	Are you vegetarian?	N / Y
History of Alcoholism?	N / Y	Do you have a partner / spouse?	N / Y
Do you smoke?	N / Y	Do you recognize the ॐ symbol?	N / Y
Are you allergic to Sulphas?	N / Y		

Please specify any additional comments for the above questions, specify allergies and medication (if any)

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5. Next of kin

Surname :..... Given name: Relation::
Cell Phone No. :..... Other Contact No. :

6. Person responsible for the payment of this account IF DIFFERENT FROM YOU.

Title: Mr/Mrs/Miss/Dr Surname: Given name:
Date of Birth: ID/Passport:
Cell phone No: Other No:
E-mail Address:
Home Address:Code:
Occupation: Employer:

7. Medical aid details (for information purpose only)

Main member: Main member Id no:
Medical aid name: Plan / Option name:
Membership number:

Terms and Conditions

We require advance EFT payments; alternatively, payment **MUST** be made directly after the appointment as we **do not** send accounts to patients. Payment accepted via cash, debit or credit card and EFT's made at the premises via your phone or our computers. Please do not ask if you can EFT from your work or home.

Although we will do our best to render the service at the time we have agreed upon, there might be situations that the patient prior to you, or an emergency patient require us to spend longer than expected. By agreeing to our services, you agree to this uncertainty. We will inform you in advance, if possible, if we are running behind schedule.

You are responsible to confirm your appointment. We reserve the right to charge you the full consultation fee as we would have lost the opportunity to fill that slot with another patient. Please have the courtesy of cancelling your appointments 24 hours in advance, should it be necessary! Appointments will be charged at R600 per hour if not cancelled.

Your health IS YOUR responsibility!! You must fully understand your treatment before we commence and you are responsible to book the follow up and maintenance appointments after completion of treatment. You are always welcome to ask questions.

The final treatment plan and costs may differ from the proposed treatment plan, as every treatment is determined by the clinical circumstance. If clinical conditions require change in treatment, details and costs will be provided before proceeding. This will however be discussed with the patient/guardian.

Due to fluctuation in the exchange rates material costs, the laboratory fees and implant component fees may differ from the amounts in the cost estimates.

Patient / Legal Guardian Signature: Name in block letters: Date:

8. Consent to make use of photos

We would like your permission to use images taken of you to showcase "extraordinary" before and after smiles, surgical procedures or facial aesthetic procedures. Photos might be used for educational purposes or for advertising purposes. Please note no names will be used. (**no photos of minors will be used at all**)

It would help us greatly if you would mark in the applicable tick boxes to authorize and give consent to use your pictures:

- ☐ Southafricadentist.com - Website
☐ The Home of Biological Dentistry's Facebook page
☐ Full-face can be shown
☐ Only teeth can be shown or procedure sites

Declaration:

- ☐ I DO consent to the use of my photos in the formats indicated above.
☐ I DO NOT consent to the use of my photos for any purpose other than my treatment.

Patient Name (Block letters): Signature: Date: