NEW PATIENT FORM

DR VC BHAGWAN

PLEASE FILL ALL ASPECTS AS THOROUGHLY AS POSSIBLE. TICK APPROPRIATE COLUMNS/BLOCKS. IF YOU ARE ON A MEDICAL AID PLEASE BRING YOUR CARD WHEN YOU COME IN. IT IS YOUR RESPONSIBILITY TO UPDATE ANY INFORMATION AT FUTURE VISITS IF THEY HAVE CHANGED. PLEASE PRINT THIS FORM AND COMPLETE IT AND BRING IT ALONG AT YOUR FIRST APPOINTMENT OR YOU CAN EMAIL THE COMPLETED FORM TO info@drbhagwan.co.za.

A. PARTICULARS OF PATIENT	
Surname of patient	
Full names of patient	
Title	
Date of birth of patient	
Id number of patient	
Occupation of patient	
Marital status	

B. DETAILS OF PERSON RESPONSIBLE FOR ACCOUNT	
Tel (H)	
Tel (W)	
Fax no	
Cell no	
Email	
Residential address	
Postal address	
Next of kin Name/Tel Number	
Family Dentist's name	
Where did you hear about us	
Referred by whom	

C. ARE YOU ON MEDICAL AID (if YES go to D, if NO go to E)		YES		NO

D. FOR MEDICAL AID PATIENTS ONLY	
Medical aid name	
Medical aid option	
Medical aid number	
Patient name as it appears on the card	
Dependant code	
DETAILS OF MAIN MEMBER	
Surname+Name	
Title	
ID Number	
Occupation	
Marital status	

E. FOR CASH PATIENTS ONLY - TO BE FILLED IN BY PERSON RESPONSIBLE FOR ACCOUNT	
Surname+Name	
Title	
ID number	
Occupation	
Marital status	
Relationship to patient	

F. HEALTH QUESTIONNAIRE OF PATIENT (if your health status changes while under treatment please inform us immediately)		
1. Please state the reason for your appointment today:		
2. Do you have/had any of the following diseases/conditions (please mark appropriate column with X for either yes or no)	Yes	No
Heart disease/prosthetic valve/congenital heart problems		
Diabetes		
Bleeding disorders/Anemia		
Allergies. If yes to what:		
High or low blood pressure		
Epilepsy		
Asthma/Hay fever or any lung problems		
Are you on any medication .If yes what is the reason:		
Are you at present pregnant. If yes which trimester/how many months pregnant		

Tonsils present		
Habits. If yes please specify type of habit:		
Are you a smoker		
Growth assessment (children under 16 years): Has your child reached puberty as yet (For girls-menstrual cycle started / For boys-cracking of voice)		
Are you at present being treated by a doctor/specialist. If yes what is the reason:		
Did any of your other family members have braces here or elsewhere?		
Have you had orthodontic treatment previously		
If yes by whom (dentist/specialist) Name:..... When did you take the braces off:.....		
3. If you have any other medical conditions not covered in the above questions please state them here:		

I, _____(name of person responsible for the account), hereby confirm that I am personally responsible for the account, notwithstanding any repudiation of any liability by my medical aid or benefit scheme/society or the workmen's compensation commissioner or insurer or whichever body. I have acquainted myself with all conditions of charges and shall undertake to pay penalties should the account be in arrears. Should I fail to pay my account, I undertake to pay legal costs relating to the recovery of the outstanding monies in respect of professional services rendered, including attorney/client fees and tracing costs. Please note that the practice will charge for appointments not kept or not cancelled at least 24 hours in advance.

I undertake to inform the practice of change of address and health status.

Signed by (name)_____ at_____on this the _____day of_____20____

Signature_____ _____ Witness_____