DENTREE DENTAL STUDIO

File No: ____________________

Date: ____________________

PATIENT INFORMATION

Title: ________ Surname: ________________ Nickname: ____________________________

Full names: ____

ID number / date of birth: ____

Gender: ☐ Male ☐ Female Age: ________

Residential Address: ____

____ Code: __________

Is patient a minor (<18 years of age)?: ☐ YES ☐ NO

If YES: 1. Who is accompanying the child today? Name: ________________________

Relation: ________________________

2. Full names of parent / legal guardian: Name: ________________________

Relation: ________________________

PATIENT / PARENT / GUARDIAN CONTACT DETAILS

Cell number: ____

E-mail address: ____

Work Details:
- Employer: ____
- Address: ____

  ____
- Telephone number: ____

MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT

Title: ________ Initials: __________________ Surname: ____________________________

Full names: ____

ID number: ____

Telephone number (H): (______) ____

Cell number: ____

E-mail address: ____

Work Details:
- Employer: ____
- Address: ____

  ____
- Telephone number: ____

Postal address: ____________________ Residential address: ____________________________

____________________ ____________________________

____________________ ____________________________

Code: ______________ Code: ______________

MEDICAL AID

Name of Medical Aid: ____

Medical Aid Option / Package: ______________________________________

Medical Aid Number: ____

Dependant Code: ____

General Practitioner: ________________________ **Contact No:** ________________

EMERGENCY CONTACT & RELATIVE

Name of emergency contact: ______________________________________

Address: ________________________ **Contact Number:** ____________________

________________________ **Relation:** ____________________________

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Name of relative (not living with you): ______________________________

Address: ________________________ **Contact Number:** ____________________

________________________ **Relation:** ____________________________

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POLICY

If covered by medical aid, we require all patients or guardians to show their medical aid cards and proof of identity when requested. We will make copies for our permanent records.

We will provide you with a treatment plan estimating your cost and medical aid benefits prior to commencing with any dental care. Our practice requests full payment at the conclusion of each visit. As a courtesy, we will be pleased to submit medical aid claims on our patient's behalf. For patients with medical aid or alternate insurance, the estimated co-payment is requested to be paid in full at the conclusion of each visit. Please note that any remaining balance, after medical payment or denial thereof after being submitted, is the patient's responsibility to settle in full within 14 days.

For treatment provided, our practice accepts cash, Edcon group cards (Edgars, Jet etc..) and major credit cards, such as Visa and MasterCard.

PAYMENT AND RELEASE OF INFORMATION AUTHORIZATION

I, ________________________________ , hereby authorize Dentree Dental Studio to furnish information concerning my or my child's oral health care to my medical aid. I know that this practice does not charge medical aid rates and I am liable for the co-payment payable immediately after treatment. Although covered by medical aid or other insurance, I am aware that I am personally responsible for all charges. I agree to pay collection and / or legal fees associated with the failure to pay my debt. A photostatic copy of this authorization will be as valid as the original. *Any co-payment surpassing medical aid tarriffs cannot be claimed back from your medical aid.

I hereby authorize Dentree Dental Studio to release the dental and medical information contained in my charts to my medical aid or insurance company for the purpose of conducting chart and claim reviews, as necessary.

________________________ ________________________

Patient Signature **Date**