DR MARK B. WERTHEIMER

Acc no. _____

BDS, M.Sc (Dent), M.Dent (Orth) Wits. FCD (SA) Orth.

SPECIALIST ORTHODONTIST

PATIENT DETAILS

SURNAME _____ FIRST NAMES _____ □ MALE □ FEMALE

HOME LANGUAGE _____ DATE OF BIRTH ___/___/___ AGE _____ Years _____ Months

PARTICULARS OF PATIENT

OCCUPATION _____ MARITAL STATUS _____ SPOUSE'S NAME _____

EMPLOYER'S NAME _____ BUS PHONE _____

CELL PHONE NUMBER _____ NAME OF MEDICAL AID _____

PRINCIPAL MEMBER OF MEDICAL AID _____ M/A NUMBER _____

MEMBERS RELATIONSHIP TO PATIENT _____ SPOUSES CELL PHONE NUMBER _____

PERSON RESPONSIBLE FOR ACCOUNT _____ ID NUMBER _____

E-MAIL ADDRESS (for accounts) _____

METHOD OF PAYMENT **□ Cash** **□ Credit card**

Please note that you are responsible for your account and that we do not deal with your medical aid.

We will, however, offer any assistance that you require in your dealings with them.

<u>Accounts are payable on presentation</u>. Interest will be charged on overdue accounts.

RESIDENTIAL ADDRESS

_____

_____

_____ CODE _____

HOME PHONE NUMBER _____

EMAIL FOR APPOINTMENT CONFIRMATION

_____

DENTIST _____ DOCTOR _____

NAME OF RELATIVE OR FRIEND (NOT SPOUSE) _____ TEL No. _____

MEDICAL HISTORY (please mark any of the following if relevant)

□ Blood disorder	□ Respiratory disorder	Tonsils	□ present
□ Heart condition	□ History of jaundice/hepatitis		□ removed
□ Rheumatic fever	□ Cortisone therapy		when _____
□ Diabetes	□ Epilepsy	Adenoids	□ present
□ Frequent headaches or facial pain	□ Possibility of HIV infection		□ removed
□ Pregnant	□ Hormone therapy		when _____

□ Allergies _____

□ Other _____

Does patient have a tendency to colds, sore throat or ear infections ? (Underline which) □ Yes □ No

List any medications that are being used _____

DENTAL HISTORY (please mark any of the following if relevant)

Have there been any injuries to the face, mouth, or teeth ? (Underline)	□ Yes	□ No	
Has the patient ever sucked a thumb or fingers ?	□ Yes	□ No	Until what age ? _____
Is the patient a mouth breather ? While awake ?	□ Yes	□ No	
While asleep ?	□ Yes	□ No	
Were any teeth removed at any time by a dentist ?	□ Yes	□ No	
(Which teeth . . . . . Age . . . . .)			
Does the patient bite the lips or finger nails, or grind the teeth ? (Underline)	□ Yes	□ No	
Have you been informed of any missing or extra permanent teeth ? (Underline)	□ Yes	□ No	
Has an orthodontist been consulted previously ?	□ Yes	□ No	
Does the patient desire treatment ?	□ Yes	□ No	
Has any member of the family had orthodontic treatment ?	□ Yes	□ No	
Does the patient have regular dental treatment ?	□ Yes	□ No	
Does the patient have any speech problems eg.lisp ?	□ Yes	□ No	

CHIEF REASON FOR SEEKING TREATMENT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHO IS THE MAJOR MOTIVATOR FOR TREATMENT ? □ SELF □ ANOTHER PERSON _____

I have read and understand the contents of the "Welcome" letter.

SIGNED _____ **DATE** ___/___/20___

CONS	RECON	RECON	SCAN	PHOTOS	CEPH	H / W	PAN	P.A CEPH	CD	L-REF	X-LET	START