

PATIENT DETAILS

SURNAME \_\_\_\_\_ FIRST NAMES \_\_\_\_\_ [ ] MALE [ ] FEMALE
HOME LANGUAGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ Years \_\_\_\_ Months
SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARTICULARS OF PARENT(S) OR GUARDIAN

FATHER'S NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_
EMPLOYER'S NAME \_\_\_\_\_ CELL No. \_\_\_\_\_ BUS. PHONE \_\_\_\_\_
MOTHER'S NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_
EMPLOYER'S NAME \_\_\_\_\_ CELL No. \_\_\_\_\_ BUS. PHONE \_\_\_\_\_
MARITAL STATUS \_\_\_\_\_ NAME OF MEDICAL AID \_\_\_\_\_
PRINCIPAL MEMBER OF MEDICAL AID \_\_\_\_\_ NUMBER \_\_\_\_\_
RELATIONSHIP TO PATIENT \_\_\_\_\_ CELL PHONE No: \_\_\_\_\_
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.

Accounts are payable on presentation. Interest will be charged on overdue accounts.

RESIDENTIAL ADDRESS \_\_\_\_\_ E-MAIL FOR APPOINTMENT CONFIRMATION \_\_\_\_\_
CODE \_\_\_\_\_

HOME PHONE NUMBER \_\_\_\_\_
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 face and mouth resemble [ ] mother [ ] father [ ] neither
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? \_\_\_\_\_

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

SIGNED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/20\_\_\_\_

Table with 13 columns: CONS, RECON, RECON, SCAN, PHOTOS, CEPH, H/W, PAN, P.A CEPH, CD, L-REF, X-LET, START