DR MARK B. WERTHEIMER

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

SPECIALIST ORTHODONTIST

PATIENT DETAILS ***ACCOUNT NUMBER*** _____

SURNAME _____ FIRST NAMES _____ □ MALE □ FEMALE

HOME LANGUAGE _____ DATE OF BIRTH / /19 AGE ____ Years ____ Months

SCHOOL _____ GRADE / STANDARD _____

PARTICULARS OF PARENT(S) OR GUARDIAN

FATHER'S NAME _____ OCCUPATION _____

EMPLOYER'S NAME _____ BUS. PHONE _____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYER'S NAME _____ BUS. PHONE _____

MARITAL STATUS _____ NAME OF MEDICAL AID _____

PRINCIPAL MEMBER OF MEDICAL AID _____ NUMBER _____

RELATIONSHIP TO PATIENT _____ CELLPHONE NUMBER _____

PERSON RESPONSIBLE FOR ACCOUNT _____ ID NUMBER _____

EMAIL ADDRESS _____

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

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

We will, however, provide you with the necessary documents for your dealings with them.

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

RESIDENTIAL ADDRESS

_____

_____

_____ CODE ____

POSTAL ADDRESS

_____

_____

_____ CODE ____

HOME PHONE NUMBER _____ FAX No. _____

DENTIST _____ DOCTOR _____

NAME OF RELATIVE OR FRIEND _____ TEL No. _____

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

□ Blood disorder
□ Heart condition
□ Rheumatic fever
□ Diabetes
□ Frequent headaches or facial pain
□ Pregnant
□ Allergies _____
□ Other _____

□ Respiratory disorder
□ History of jaundice/hepatitis
□ Cortisone therapy
□ Epilepsy
□ Possibility of HIV infection
□ Hormone therapy

Tonsils □ present □ removed when _____

Adenoids □ present □ removed when _____

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 at 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 short letter welcoming me to the practice.

SIGNED _____ **RELATIONSHIP TO PATIENT** _____ **DATE** / /201

CONS	RECON	RECON	MODELS	PHOTOS	CEPH	H / W	PAN	O.P.	P.A CEPH	I/O. RAD	CD	L-REF	X-LET	START