Dr Jonathan Cohen
B.Ch.D. (Stell)
PDD Paediatrics (Stell)

Dr David Sheinbar
B.D.S. (Wits)
PDD (Stell)

Annex 116 Milnerton Mediclinic
Racecourse Road
Milnerton

Welcome to our practice!

Please read through the following pages and complete accordingly. It is in your own interest and for your own safety that you answer the questions carefully and truthfully. Please be assured that all answers will be treated in the strictest of confidence.

Thank you.

Patient Particulars

Surname:…………………………………………………………………….Mr/Mrs/Ms/Miss/Master/Dr/Prof

First Names:……………………………………………………………………………………………….

Date of Birth:…………………………………………………..I.D.Number:…………………………………..

Address:…………………………………………………………………………………………………

…………………………………………………………………………Postal Code:…………………………..

Telephone: (H)………………………………(W)……………………………(Cell)……………………………...

Occupation:……………………………………………………Employer:……………………………………..

Referred By:………………………………………………………………………………………………..

Particulars of Person Responsible for Payment

Surname:…………………………………………………………………..Mr/Mrs/Ms/Miss/Master/Dr/Prof

First Names:……………………………………………………………………………………………….

I.D.Number:………………………………………………Employer:…………………………………………

Address:…………………………………………………………………………………………………

………………………………………………………………………………Postal Code:……………………...

Telephone: (H)………………………………(W)……………………………(Cell)……………………………...

Medical Aid Scheme:………………………………………………………………………………………

Medical Aid Number:………………………………………………………………………………………

Medical History

1. How would you describe your present health?…………………………………………..Good/fair/poor

2. Have you been under the care of a medical doctor in the past two years?…………………………………

3. Have you been hospitalised in the last five years?………………………………………………………

4. Have you been under medication of any sort in the last two years?……………………………………….

5. Are you allergic to anything? (food/drugs/latex)……………………………………………………..

6. Does any medication give you an unpleasant reaction?…………………………………………………

7. Have you had a bad reaction to local or general anaesthetic?……………………………………………...

8. Have you ever had excessive, prolonged bleeding requiring attention?…………………………………...

9. Do you suffer from shortness of breath?…………………………………………………………………...

10. Name of family doctor/physician……………………………………..Doctors Tel No:…………………..

11. Please indicate which of the following you have had in the past, whether you still suffer from the condition or not:-

- ❑ Heart disorders
- ❑ Heart attack
- ❑ Angina Pectoris
- ❑ Heart murmur
- ❑ Valvular disease
- ❑ Rheumatic Fever
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart surgery
- ❑ Cardiac Pacemaker
- ❑ Congenital heart disease
- ❑ Heart valve replacement
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Chronic lung disease
- ❑ Asthma
- ❑ Sinus trouble
- ❑ Bleeding disorders
- ❑ Blood clotting disorders
- ❑ Kidney disease
- ❑ Hepatitis
- ❑ Epilepsy
- ❑ Thyroid problems
- ❑ Stroke
- ❑ Arthritis
- ❑ Anemia
- ❑ Night sweats
- ❑ Porphyria
- ❑ Diabetes
- ❑ Chemotherapy
- ❑ Glaucoma
- ❑ Artificial joints
- ❑ Nervous disorders
- ❑ Glandular swellings
- ❑ Jaundice

12. Are you taking any of the following medications?

- ❑ Heart drugs
- ❑ Steroids
- ❑ Blood pressure pills
- ❑ Pain killers
- ❑ Anticoagulants
- ❑ Cold/flu medication
- ❑ Antibiotics
- ❑ Tranquillisers
- ❑ Sleeping pills
- ❑ Sedatives
- ❑ Thyroid drugs
- ❑ Oral contraceptives

13. Please list any other medication you may be taking that is not listed above……………………………….

……...

14. Do you suffer from any other condition not listed?……………………………………………………………..

………..

15. Do you smoke?…………………………If yes, how many per day?……………………………………

16. Have you ever been tested for HIV/Aids?………………………………………………………..

17. Was the result positive or negative?………………………………………………………………

18. When were you last tested?……………………………………………………………………….

19. **<u>For Female patients</u>**

    a) Are you pregnant or think you might be pregnant?……………………………………………….

    b) If yes, how far into your pregnancy are you?……………………………………………………

    c) Are you breast feeding?………………………………………………………………………

20. Is there any other medical information that may be important for us to know?…………………………...

………

Dental History

1. What is the nature of your present complaint?…………………………………………………………
2. How long have you had the problem?……………………………………………………………..
3. Are you nervous about seeing a dentist?……………………………………………………………..
4. Have you ever had an unpleasant experience at the dentist?………………………………………

………

5. How often do you brush your teeth?..
6. Do you floss your teeth?.......................If yes, then how often?...
7. When last did you see an oral hygienist?...
8. Have you ever consulted a dental specialist?..
9. Who was your previous dentist?...
10. Why have you left that dentist?...

Thank you for your co-operation.

Signature:…………………………………………………Date:……………………………

Dear patient

Please take a few moments to read through the following and sign in the relevant space below.

The medical and dental industry has changed dramatically over the last few years especially in the funding of treatment by third parties (medical aid schemes). In years gone by medical aids paid almost all dental accounts without fuss but things have changed steadily over the past ten years. In order for you to consider the fees we are quoting, you need to be aware of the background to determining fees, so that you do not confuse the “medical aid benefit” with the fee we are charging.

The health professions council of South Africa has scrapped their dental tariffs from 1 January 2009. All medical schemes base their benefits on the National Health Reference Price List which is not a set of tariffs but intended to serve only as a baseline against which medical schemes individually determine benefit levels.

In order to provide a quality dental service to our patients, this practice is unable to operate at those “medical aid rates”. Our fees are based on the actual costs of running a practice as well as our expertise and experience and have based our fees on the “ethical tariffs” previously determined by the Health Professions Council of South Africa.

We strongly recommend that, if applicable, you submit the treatment cost estimate to your funder, before commencing treatment, so that you are able to determine what, if any, portion of your account will be retrievable and for how much you will be personally responsible.

All accounts must be settled on the day of treatment. Quotes will be provided on request but in this regard please be advised that treatment may change as demanded by clinical circumstances during treatment therefore procedures and fees may change accordingly.

We accept cash, cheques, internet transfers and most credit cards to assist you in settling your account. Please note that internet payments must be effected within 48 hours or 2 working days from date of treatment.
A fee will be levied for all failed appointments or those not cancelled at least 24 hours in advance. Patient reminders the day before appointments are a courtesy and cannot be used as an excuse for a failed appointment. Cell phone messages are not always reliable.
Overdue accounts will be handed directly to a credit bureau and patients may be blacklisted.

These measures have become necessary so that we can continue to provide a caring, friendly and professional service to everyone.

I certify that:

- I understand and accept the tariff and terms
- I take full responsibility to pay for services rendered to myself and/or my dependants
- I undertake to settle the account upon receipt thereof
- I agree that should I fail to settle my account, my overdue account will be handed over for collection
- Should my account be handed over for collection, I understand that I will be liable for all legal costs, including attorney and own client cost, collection fees, tracing costs, disbursements and any other necessary costs which may be incurred and agree that my personal details may be listed with a credit bureau

Name:……………………………………………Signed:………………………Date:…...................