Dr Johann Lochner

BChD (Stell), MFGDP (UK), MFDS RCS (Eng), MChD OMP (UWC)

ORAL MEDICINE/PERIODONTICS

MONDGENEESKUNDE/PERIODONSIE

ACCOUNT NO :

FILE NO :

1 Patient Details

Pasiënt Besonderhede: **Date/Datum:**

Surname: Van :	First Name: Voornaam :
Date of Birth : Gender: Geboortedatum: Geslag:	I.D. Number : I.D. Nommer:
Occupation: Beroep :	Home Language: Marital Status : Huistaal : Huwelikstatus :
Home Tel No. : Huis Tel No. :	Work Tel No. : Werk Tel No. :
Email address :	Cell No:

11 Person Responsible for Account

Persoon Verantwoordelik vir Rekening

Full Name : Volle Naam:	Mr/Mrs/Miss : Mnr/Mev/Mej:
Home Address: Woonadres :	I.D. Number: I.D. Nommerr:
	Tel: Home: Tel: Huis :
Work Address: Werksadres :	Tel: Work: Tel: Werk:
Postal Address: Posadres :	Cell No: Sel Nr :

111 Medical Aid

Mediese Fonds

Medical Aid: Mediese Fonds:	Number : Nommer:
Member's Name: Hooflid se Naam:	I.D. Number: I.D. Nommer:

1V Nearest Family/Friend

Naaste Familie/Vriende

Name: Naam:	Relationship : Verwantskap:
Address: Adres :	Code: Tel: Kode:

V Referred By

Verwys deur

Name: Naam:	
Address: Adres :	Code: Tel: Kode:

I Family Doctor:

Familie Geneesheer:

P.T.O.

I declare that the above information is correct. I also understand that this practice has no agreement with any medical aid scheme for direct invoicing and take responsibility for settlement of the account. Please note, Dental Cone Beam Scan will not be covered by your Medical Aid. This practice has a 24 hour cancelation policy and I understand I will be held accountable for a cancelation fee if an appointment was missed or cancelled on the day.

Ek verklaar dat die bostaande inligting korrek is. Ek verstaan dat die praktyk geen ooreenkoms met 'n mediese fonds het vir direkte betaling van die rekening nie, en aanvaar verantwoordelik vir die vereffening daarvan. Let asb. wel dat u mediese fonds nie Tandheelkundige "Cone-Beam Scan" dek nie. Hierdie praktyk het 'n 24 uur kanselasie beleid en ek verstaan ek sal verantwoordelik gehou word vir 'n kanselasie fooi indien ek 'n afspraak nie bywoon nie of op die dag van 'n afspraak kanseleer.

The undersigned signatory to this schedule binds himself/herself as surety and co-principal debtor for the punctual payment, by the patient and/or the person responsible for the account, of all amounts due to Dr Johann Lochner. In the event that it becomes necessary to institute legal proceedings to enforce payment of any amount due to Dr Johann Lochner, the party liable therefore shall pay all the fees and disbursements in connection therewith on the scale between attorney and own client. The signatory chooses his / her home address given as above as the domicilium et executandi address.

Die ondergetekende verbind hom-/haarself as borg en medehoofskuldenaar vir die tydige betaling, deur die pasiënt en/of die persoon verantwoordelik vir die rekening, vir alle gelde betaalbaar aan Dr Johann Lochner, ter vereffening van sy rekening. Indien Dr Johann Lochner genoodsaak word om regstappe te neem ter invordering van gelde aan hom verskuldig, sal die party verantwoordelik vir die rekening, ook verantwoordelik wees vir alle regkostes en uitbetalings aangegaan soos betaalbaar teen prokureur eie-kliënt skaal. Die ondergetekende kies sy / haar bostaande tuis adres as die domicilium et executandi addres.

Patient/Parent/Guardian's Signature:
Date/Datum: ____________________ Pasiënt/Ouer/Voog Handtekening: ________________________

PLEASE ANSWER ALL THE QUESTIONS
VOLTOOI DIE VRAELYS ASSEBLIEF (Indicate with a cross)

	Yes	No
1. Have you been in hospital or treated by a doctor for a serious condition during the last 2 years? / Was u die afgelope 2 jaar in ‘n hospitaal behandel of deur ‘n dokter behandel vir ‘n ernstige kwaal?	_____	_____
2. Have you undergone any operations/Enige operasies gehad?	_____	_____

Specify if yes: ________________________________
Spesifiseer indien ja: ________________________________

	Yes	No
3. Are you pregnant/Is u tans swanger?	_____	_____
4. Are you currently under medical treatment/Is u onder dokters behandeling?	_____	_____
5. Do you use any medication/Neem u enige medikasie?	_____	_____

Specify if yes: ________________________________
Spesifiseer indien ja: ________________________________

6. Do you take Disprin or any other anti-coagulant medication / Neem u Disprin of enige andere anti-koagulasie medikasie?
Specify if yes: ________________________________
Spesifiseer indien ja: ________________________________

7. Do you smoke/Rook u? ________________________
If yes, specify how many per day: ________________________
Indien ja, spesifiseer hoeveel per dag: ________________________

8. Are you allergic to any Medication, eg Penicillin? ________________

	Yes	No
9. Have you ever been treated with chemotherapy / Is u met chemoterapie of bestraling behandel	_____	_____
10. Have you been diagnosed with osteoporosis / Is u al gediagnoseer met osteopororse?	_____	_____

If yes, specify wat medication was used / Indien ja, spesifiseer watter medikasie is gebruik
____

11. Have you ever, or are you suffering from any of the following/Ly u aan, of het u enige van die volgende siektes gehad? (Tick appropriate item if yes and a cross if no / Merk met ‘n regmerk indien van toepassing en ‘n kruisie indien nie)

- Bleeding problems/Bloedingsneigings
- Hypertenstion/Hipertensie
- Angina/Angina
- Lung diseases/Longkwale
- Tuberculosis/Tuberkulose
- Porphyria/Porfirie
- Diabetes/Diabetes
- Psychological treatment/Sielkundige behandeling
- Allergies/Allergieë
- Heart failure/Hartversaking
- Heart murmurs/Hartgeruise
- Asthma/Asma
- AIDS/VIGS
- Jaundice/Geelsug
- Kidney diseases/Niersiektes
- Heart disease/Hartsiektes
- Myocardial Infarction/Miokardiale Infark
- Transplant/bypass/Klepvervanging/omleiding
  - Chronic Bronchitis/Chroniese Brongitis
- Hepatitis/Hepatitis
- Gastric Ulcer/Maagseer
- Epilepsy/Epilepsie
- Stroke/Beroerte

I declare that the above information is correct. / Ek verklaar dat die bostaande inligting korrek is.

Date/Datum: ____________________

Patient/Parent/Guardian’s Signature:
Pasiënt/Ouer/Voog Handtekening: ________________________

Witnessed by/Nagegaan deur: ____________________