Dr. Sidonija Madjarević
BSc, BSc (Hons), BDS (Wits)

Dental Surgeon
Practice Number: 0540000504971

PATIENT DETAILS

Patient Name:	Surname:
Date of Birth:	Patient ID Number:
Address:	
Postal Address:	
Tel (Home):	(Work):
(Cell):	E-mail:
Referred by:	

MEDICAL AID DETAILS

Medical Aid Name:
Medical Aid Number:
Medical Aid Plan:
Main Member:

PERSON RESPONSIBLE FOR ACCOUNT

Name:	Surname:
Address:	
Tel (Home):	(Work):
(Cell):	E-mail:
ID Number:	

NAME OF FRIEND OR RELATIVE (DIFFERENT TO ABOVE)

Name:	Surname:
Address:	
Tel (Home):	(Work):
(Cell):	Relation:

HEALTH QUESTIONNAIRE

PATIENT DETAILS

Name/s:	Surname:

MEDICAL PRACTITIONER'S DETAILS

Name:
Address:
Tel No:

PATIENT'S HEALTH DETAILS

How would you describe your present health?	Good	Fair	Poor
Are you being treated by a Specialist?	No	Yes	
If YES, please give details:			
Have you been admitted to hospital or have been under a doctor's treatment within the last 2 years?	No	Yes	
If YES, please give details:			

ALLERGIES TO MEDICATION OR DRUGS

INDICATE ANY OF THE FOLLOWING WHICH YOU MAY CURRENTLY HAVE OR HAVE HAD – PLEASE INDICATE WITH A (✓) OR (×)

	NO	YES	DETAILS
WEIGHT LOSS			
INFECTIONS			
PSYCHIATRIC CARE			
KIDNEY DISEASE			
SINUS			
DIARRHOEA			
DIABETES			
GLAUCOMA			
PORPHYRIA			
EPILEPSY			
STROKE			
ATHIRITIS			
GLANDULAR SWELLING			
CONGENITAL HEART LESION			
HEART MURMUR			
RHEUMATIC FEVER			
CARDIAC PACEMAKER			
VALVE PROSTHESIS			
ANY OTHER:			

VASCULAR CONDITIONS			
	NO	YES	DETAILS
HIGH BLOOD PRESSURE			
LOW BLOOD PRESSURE			
BLOOD CLOTTING DISORDERS			
BLEEDING TENDENCY			
LUNG CONDITIONS			
	NO	YES	DETAILS
ASTHMA			
TUBERCULOSIS			
NIGHT SWEATS			
H.I.V. / VIGS			
	NO	YES	DETAILS
I HAVE H.I.V. AIDS			
HIGH RISK GROUP			
LIVER DISORDERS			
	NO	YES	DETAILS
HEPATISIS/ JAUNDICE			
HIP/ KNEE REPLACEMENTS			
	NO	YES	DETAILS
HIP/ KNEE REPLACEMENTS			
MEDICATION / TABLETS			
ARE YOU TAKING ANY MEDICATION OR TABLETS? – IF YES, PROVIDE DETAILS:			
HAVE YOU TAKEN ANY OF THE FOLLOWING?			
	NO	YES	DETAILS
ANTI-DEPRESSANTS?			
TRANQUILLISERS?			
CORTISONE?			
BLOOD THINNERS?			
FEMALE PATIENTS			
	NO	YES	DETAILS
ARE YOU PREGNANT?			
ARE YOU ON THE PILL?			
DO YOU HAVE ANY DISEASE, PRE-EXISTING CONDITIONS OR MEDICAL PROBLEMS NOT LISTED ABOVE THAT YOU FEEL WE SHOULD BE AWARE OF? IF SO, PLEASE GIVE DETAILS:			

I, THE UNDERSIGNED, STATE THAT THE INFORMATION GIVEN ABOVE IS COMPLETE AND CORRECT.

SIGNATURE

DATE

TERMS AND CONDITIONS OF PATIENT/ DENTAL SURGEON RELATIONSHIP

1. ACCEPTANCE:

   The undersigned acknowledge that he/she shall be liable for the amount to be charged by the dentist indicated on the face hereof after the consultation, inclusive of any required material used by the dentist indicated on the face hereof, medicine supplied, etc.

2. TERMS OF PAYMENT:

   2.1. Every payment by the responsible person arising out of or in connection herewith shall be made at the dentist indicated on the face hereof surgery free of any deductions and with set-off on the due date and without demand.

   2.2. Unless otherwise agreed to in writing:

   - 2.2.1. The dentist indicated on the face hereof will bill the responsible person after the consultation or having affected the service;
   - 2.2.2. Payment shall be made immediately in respect of any such bill but not later than 30 days from the date of statement;
   - 2.2.3. The dentist indicated on the face hereof will send the statement to your medical aid, but shall not relieve the responsible person from liability in terms of the agreement;
   - 2.2.4. Any payment made by the responsible person or his/her medical aid may be appointed by the dentist indicated on the face hereof to such liability of the responsible person to the dentist indicated on the face hereof as he in his sole and absolute discretion may decide, and the responsible person waives the right to indicate or name the debt to which any such payment shall be applied.
   - 2.2.5. Interest at the margin of 4% per month above the prime bank rate specified by _______________ Bank from time to time shall be charged by the dentist indicated on the face hereof at his discretion on any amount not paid by the responsible person on due date. The amount shall be calculated monthly in advance on the outstanding balance due on the first day of each calendar month and shall be so calculated and capitalised on the same day of each and every month until the total amount due in terms hereof shall have been paid.

3. BREACH:

   Should –

   3.1. the responsible person fail to make payment of any amount owing to the dentist indicated on the face hereof on due date;

   or

   3.2. the responsible person be provisionally or finally sequestrated or wound-up or liquidated or placed under judicial management or any of his/her assets be attached pursuant to a judgement of any competent Court, or a default judgement be entered against the responsible person in any competent court:

   the name of the competent person and names of his/her dependants shall be put on a credit control list for the medical profession, the Cred-Alert list.

4. NOTICES AND DOMICILIA:

   4.1. The parties respectively choose *domicilia citandi et executandi* for the purposes of all notices and processes arising out of or in connection with this agreement as follows:

   - 4.1.1. The dentist indicated on the face hereof: Bedford Axis, 6 Bradford Road, Bedfordview;
   - 4.1.2. Responsible Person: At the street address on the face hereof.

   4.2. Any notice sent by either party to the other shall be deemed to be received on the seventh day after the date of posting or on the date of delivery in the case of delivery by hand.

   4.3 Each party shall be entitled to change the address specified by it in terms of the clause to any other address within the Republic of South Africa (not being a post office box or poste restante) on not less than 14 Days prior written notice to the other party.

5. GENERAL:

   5.1 This agreement constitutes the whole and entire agreement between the parties and there have not been and there are no agreements, representations or warranties between the parties other than those specifically set forth herein.

   5.2. No variation or modification of this agreement shall be of any force or effect unless the same shall be confirmed in writing and signed by the parties.

   5.3. No indulgence on the part of either party in exercising any right conferred upon such party in terms of this agreement shall constitute a waiver or novation of any such right, nor shall any single or partial exercise of any other right under this agreement.

6. COSTS:

   6.1. All legal and collection costs. Including attorney and client costs, charges and disbursements incurred by the dentist indicated on the face hereof in collecting or endeavouring to collect all or any amount payable by the responsible person hereunder, shall be for the account of the responsible person and payable on demand.

7. CERTIFICATE OF INDEBTNESS:

   7.1. The indebtness of the responsible person to the dentist indicated on the face hereof in terms of the contract shall be determined and conclusively proved for all purposes by a certificate signed by the dentist indicated on the face hereof.

SIGNATURE

DATE