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ORTHODONTIST
PR NO: 0640000005665

PATIENTS ARE KINDLY REQUESTED TO COMPLETE THIS QUESTIONAIRE

Particulars of Patient

Surname …….. First Name ……
Date of Birth …… Age …….. Sex ……..
Home Language ……..
Family Dentist …….. By whom were you referred? ……
Has patient previously visited an Orthodontist? ……..
If so, which Orthodontist and when? ……

Patient's Medical History

1. Are you taking any medication? ……
2. Are you allergic to any medication? ……..
3. Indicate whether you have had any of the following conditions:

Rheumatic Fever …….. Heart Disease ……
Epilepsy …… Bleeding tendency ……
Diabetes …… Other ……

Person responsible for the payment of the account:

Surname …… First Name …… Initials ……..
Title (Mr, Mrs) …… Marital Status ……

If divorced, contact details of mother / farther to be included in this questionnaire.

Street Address…….. Postal Address ……
…….. ……..
…….. ……..
Postal Code …….. Postal Code ……..
Telephone (work) …… Home ……..
Cellphone …….. Email ……
Name of Medical Aid …… Membership # ……
ID Number of Main Member …… Employer ……..

Street Address…….. Postal Address ……
… …….. ……..
…….. ……..
Postal Code …….. Postal Code ……..
Telephone (work) …… Home ……..
Cellphone …….. Email ……

Date …… Signature ……..

Submit your form