DR. STÉFAN BESTER

B.Ch.D., M.Ch.D (Pret)

PROSTHODONTIST

Title:	**PATIENT** Surname:	Marital Status:
Full name:		
Date of birth:	ID:	
Home Address:		
		Code:
Postal address:		
		Postal Code:
E-MAIL:		CELL NO:
Tel (W):	Tel (H):	Fax:
Employer: Name & Address:		
PROFFESSION		Postal Code:
SENIOR MEMBER to whom the account must be addressed:		
Surname:	Full Name:	Title:
Date of Birth:	ID:	Cell No:
MEDICAL SCHEME:	**Number:**	Marital Status:
Home address:		
		Code:
Postal address:		
		Postal Code:
Tel (W):	Tel (H):	Fax:
Employer: Name & address:		
PROFFESSION		Postal Code:
E-MAIL:		

Patients are requested to notify us of any changes as soon as possible.

Name of your Dentist:	Tel:
Name of your Medical Practitioner:	Tel:
Name of person that referred you:	Tel:
Referral (Not immediate family)Name:	Tel:
Address:	Postal Code:

Medical History: Have you ever had the following?				**Please mark if YES**
☐ HIV status	☐ Hay Fever	☐ Porphyria	☐	Do you take medication regularly?
☐ Heart disease	☐ Asthma	☐ Epilepsy	☐	Do you smoke?
☐ Rheumatic fever	☐ Tuberculosis	☐ Do you often get headaches?	☐	**Ladies:** Are you pregnant?
☐ High/low blood pressure	☐ Lung problems	☐ Hormonal problems	☐	If so How many months?
☐ Anaemia	☐ Diabetes	☐ Arthritis		
☐ Blood clotting problems	☐ Jaundice or liver problems	☐ Are you allergic to anything?		

If you answered YES, please provide more detail:

Have you ever had any other serous disease?

Dental History: What is the purpose of your visit?

☐ Have you experienced abnormal reactions with dental injections?	☐ Are you conscious of any mouth habits e.g. clenching or grinding?
☐ Have you any pain or discomfort in the mouth?	☐ Do you experience any pain in the joints of your jaw?
☐ Have you noticed any odours or bad taste?	☐ Has a dentist or oral hygienist shown you how to clean your teeth?
☐ Have you had any gum treatment?	

UNDERSIGNED CERTIFIES THAT HE/SHE IS AUTHORISED TO CONTRACT ON BEHALF OF THE SENIOR MEMBER AND THAT ALL INFORMATION IS CORRECT AND ACKNOWLEDGES THAT ANY AMOUNT DUE FOR GOODS AND SERVICES WILL BE DUE UNCONDITIONALLY.

…….. …… ……..

Signed Name Date