

# NEW PATIENT REGISTRATION FORM

## Welcome to Westrand Dental Centre!

### Pasiënt Besonderhede / Patient Details:

Titel / Title

Van / Surname

Volle Name / Full  
Names

Male

Female

Date of Birth

ID Nommer /  
Number

Who Referred you  
to this Practice?

Huis adres /  
Residential  
Address

Werk adres /  
Work Address

Pos adres /  
Postal Address

Tel: Huis / Home

Tel: Werk / Work

Tel: Sell / Cell

Tel: Fax

Epos /Email

**Mediese Fonds / Details of Medical Aid:**

Naam / Name

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Skema / Scheme

---

Nommer / Number

---

Opsie / Option

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**Persoon verantwoordelik vir rekening / Person responsible for account:**

Same as above

Titel / Title

---

Van / Surname

---

Volle Name / Full  
Names

---

Male

---

Female

---

Date of Birth

---

ID Nommer /  
Number

---

Who Referred you  
to this Practice?

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Huis adres /  
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Pos adres /  
Postal Address

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Tel: Huis / Home

---

Tel: Werk / Work

Tel: Sell / Cell

Tel: Fax

Epos /Email

**Kontak nommer van a friend of family lid / Contact number of a friend or family:**

Naam / Name

Werwantskap aan hooflid / Relation to Main member:

Tel: Huis / Home

Tel: Werk / Work

Tel: Sel / Cell

**Mediese Geskiedenis / Medical History:**

- |   |  |
|---|--|
| <input type="checkbox"/> Rumatiekkoors / Rheumatic fever  | <input type="checkbox"/> Sinus                                       |
| <input type="checkbox"/> Diabeet / Diabetes   | <input type="checkbox"/> Apilepsie / Epilepsy                        |
| <input type="checkbox"/> Bloeddruk / Blood pressure: H / L  | <input type="checkbox"/> Asma / Asthma                               |
| <input type="checkbox"/> Rook / Smoke   | <input type="checkbox"/> Stolling probleme / Clotting Problems       |
| <input type="checkbox"/> bloed Armoede / Aneamia  | <input type="checkbox"/> Dames, Swanger / Ladies, Pregnant           |
| <input type="checkbox"/> Hartaandoenings / Heart Conditions   | <input type="checkbox"/> Neem U Kortisoon / Are you taking cortisone |
| <input type="checkbox"/> Enige abnormale reaksie met tandheelkundige inspuitings / Any Abnormal reaction to dental injections |  |
| <input type="checkbox"/> Bloei U Tandvleis / Do your Gums Bleed   |  |
| <input type="checkbox"/> Kry U gereeld Mondseer / Do you suffer from frequent Ulcers  |  |
| <input type="checkbox"/> Enige los tande / Any loose Teeth  |  |
| <input type="checkbox"/> Slegte Asem / Bad Breath   |  |
| <input type="checkbox"/> Kners U op U tande / Do you grind or clench  |  |
| <input type="checkbox"/> Pyn in U Kaakgewrig / Pain in the joints of you Jaw  |  |

- Enige vorige Tandheelkundige operasies / any previous Dental operations
- Ortodontiese Behandeling / Orthodontic treatment
- Was U al gewys hoe om U tande Korrek te Borsel / Have you been shown how to brush your teeth

Allergieë / Allergies:

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Is U tans gespanne / Are you more Tense:

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Huidige Medikase / Current Medication:

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Indien Ja, Spesifiseer / If Yes, Please specify:

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Ek Verklaar dat alle bostaande inligting korrek is en dat ek verantwoordelik is vir betaling van enige rekening tot en met vereffening, of nie, deur die mediese fonds.

I declare that all information above is correct, and that I am responsible for the payment of any accounts until, or if not, settled my the medical Aid.

Enige uistaande rekeninge ouer as 120 dae sal oorhanding work aan ons prokureurs vir invordering.

Any accounts older than 120 days will be handed over to our attorneys for collection.

- Ek aanvaar hiermee die terme en voorwaardes / I accept the term and condition.