Dr Barnard
DENTAL CARE

Registration Form

We need this information to provide the best quality care. This form complies with the HPCSA standards for medical and dental practices. This means your personal information is kept private and secure, as required by privacy laws (POPI Act). If you have concerns, please leave blank and discuss with receptionist.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records..

PATIENT INFORMATION

Title: Surname: First Name(s):

Gender: ☐ Male ☐ Female Date of Birth: / /

ID Number:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address:

Province: Postal Code:

Home Phone: Cellphone:

Email Address:

Next of Kin Name:

Contact Number: Relationship:

PERSON RESPONSIBLE FOR ACCOUNT

☐ **Same as above**

Title: Surname: First Name(s):

ID Number:

Home Address:

Province: Postal Code:

Home Phone: Cellphone:

Email Address:

Medical Aid Provider: Member Number:

Plan Name: Dependent Code:

Dr Barnard DENTAL CARE

MEDICAL HISTORY

Health Professional Council of South Africa requires that Medical History Forms be updated every 6 months

Please Tick YES (Y) or NO (N)					
	Y	N		Y	N
High Blood Pressure			Stomach Ulcers		
Bleeding Problems			Asthma		
Are you taking any blood thinners? E.g., Aspirin, Dispirin, Warfarin, Plavix, Ecotrin.			Tuberculosis?		
Rheumatic Fever			Porphyria		
Hip / Knee Replacement			Epilepsy		
Osteoporosis			Pregnant		
Bisphosphonate Treatment			Are you currently taking any birth control medication?		
Diabetes			Are you a smoker?		
Radiation or Chemotherapy			Any previous reaction to a dental injection?		
Hepatitis			Any Recent Surgery?		

Allergies and/or any other illness not mentioned above?

_____

_____

Medical Doctor Name: _____

_____ _____

PATIENT/GAURDIAN SIGNATURE **Date**

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Consent Form

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by email, telephone or SMS for your appointment, treatment specials, and follow up reminders.

I consent to being contacted with reminders to help me maintain my health ☐ YES ☐ NO

PATIENT INFORMATION PRIVACY POLICY

This Dental Practice Requires Your Consent....
We ask you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat, and be proactive in your health care needs.

** Please note, this practise reserves the right to discontinue treatment **
Where information given by the patient is incorrect or incomplete.

Your information will be used for:

- Administration purposes in running our practice.
- Billing purposes, including complying with the requirements of Medicare and the Health Insurance Commission.
- Quality Assurance activities and research purposes such as accreditation (patient identity will not be disclosed).
- For infectious disease notification – as required by law.
- For legal purposes, e.g. Subpoena or Court order – as required by law.
- Disclosure to others involved in your health care, including treating doctors, and specialists outside this medical practice, i.e. through referral, medical test, reports or results.
- We send all our prescriptions electronically and may view the history of any of your prescribed or dispensed prescriptions.

If you do not wish for your records to be accessed for these purposes, please inform the doctor so that he may note this in your record.

I have read the information above and I ...

Understand the reasons for patient information collection.
Understand this practice has a privacy policy on handling patient information
Understand that I am not obliged to provide the information requested, but that failing to do so might compromise the quality of health care treatment given to me.
Understand that if my information is to be used for any other purposes other than set out above, further consent must be obtained.
I am aware of my right to access the information collected except in circumstances where access might legitimately be withheld. Such circumstances will require explanation.

I am aware that if my medical aid does not cover the cost of the procedures in full, then I am liable to cover the remaining balance in full. I accept responsibility for all monies not paid by my medical aid. In the event of money being paid directly to me by my medical aid, I agree to pay the full amount to the practice within 7 days. I agree that interest as per the Usury act may be charged for amounts overdue. The signatory hereto agrees to pay all legal costs should it occur.

PATIENT/GAURDIAN SIGNATURE **Date**