Dr Pierre Ferreira Orthodontist

B.Ch.D. M.Sc. (Odont). M.Ch.D. (Ort) Pretoria

Practice number 6401392

WELKOM BY ONS PRAKTYK / WELCOME TO OUR PRACTICE

DATUM / DATE Y Y Y Y M M D D AFR ☐ ENG ☐

PASIëNT SE BESONDERHEDE / PATIENT'S DETAILS

NAAM / NAME

VAN / SURNAME

GEBOORTEDATUM / DATE OF BIRTH Y Y Y Y M M D D GESLAG / SEX M ☐ F/V ☐

OUDERDOM / AGE

E-POS / EMAIL

WERKGEWER / EMPLOYER

HUIS / HOME TEL | SEL NO / CELL NR | WERK / WORK TEL

BESONDERHEDE VAN REKENINGPLIGTIGE / DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT

VAN / SURNAME TITEL / TITLE:

VOLLE NAME / FULL NAMES

ID NO /ID NR

E-POS / EMAIL

WERKGEWER / EMPLOYER

HUWELIKSTATUS/MARITAL STATUS GETROUD/MARRIED ☐ GESKEI/DIVORCED ☐ WEDUWEE/WIDDOW ☐

WOONADRES / RESIDENTIAL ADDRESS

POSKODE / POSTAL CODE

POSADRES / POSTAL ADDRESS

POSKODE/POSTAL CODE

HUIS / HOME TEL | SEL NO / CELL NR | WERK / WORK TEL

BESONDERHEDE VAN GADE OF METGESEL / DETAILS OF SPOUSE OR PARTNER

VAN / SURNAME TITEL / TITLE:

VOLLE NAME / FULL NAMES

ID NO / ID NR

E-POS / EMAIL

WERKGEWER / EMPLOYER

HUIS / HOME TEL | SEL NO / CELL NR

MEDIESE FONDS BESONDERHEDE / MEDICAL AID DETAILS

MEDIESE FONDS / MEDICAL AID

LID NOMMER /MEMBER NUMBER

PLAN

AFHANKLIKE KODE / DEPENDANT CODE

BESONDERHEDE VAN NAASBESTAANDE / DETAILS OF A RELATIVE

NAAM / NAME: TEL:

IS ENIGE FAMILIE OF VRIENDE PASIëNTE VAN ONS?/DO YOU HAVE FAMILY OR FRIENDS AS PATIENTS OF OURS?

WIE HET U NA ON TOE VERWYS? / WHO REFERRED YOU TO US? √

TANDARTS / DENTIST ☐ NAAM / NAME

WEB TUISTE / WEBSITE ☐ ADVERTENSIE / ADVERT ☐ VRIENDE/FRIENDS ☐ FACEBOOK ☐

"Die persoon verantwoordelik vi rdie rekening kies die bogemelde huisadres as DOMICILIUM ET EXECUTANDI vir die doeleindes van die betekening van prosesstukke en kennisgewings by die bogemelde woonadres, wat slegs verander kan word deur 7 dae kennisgewing by wyse van aangetekende pos"

"The person responsible for the account choose DOMICILIUM CITAND ET EXECUTANDI at the abovementioned home address for the purpose of service of all procese and notices, which address may be changed by means of a 7 day written notice by registered post".

HANDTEKENING VAN OUER OF VOOG /
SIGNATURE OF PARENT OR GUARDIAN

HOOFREDES VIR ORTODONTIESE BEHANDELING / MAIN CONCERNS FOR ORTHODONTIC TREATMENT?

MEDIESE GESKIEDENIS / MEDICAL HISTORY

HET U ENIGE VAN DIE VOLGENDE GEHAD? / HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ ORTODONTIESE BEHANDELING / ORTHODONTIC TREATMENT
- ☐ BESERINGS AAN GESIG, MOND, TANDE / INJURIES TO FACE, MOUTH, TEETH
- ☐ PYN IN KAAKGEWRIG / PAIN IN JAW JOINT
- ☐ MANGELS VERWYDER / TONSILS REMOVED

GEBRUIK U TANS ENIGE MEDIKASIE? / ARE YOU CURRENTLY USING ANY MEDICINE?

MEDISYNE WAARVOOR U ALLERGIES IS? / ARE YOU ALLERGIC TO ANY MEDICINE?

HET U VAN DIE VOLGENDE TOESTANDE GEHAD? / HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ ABNORMALE BLOEDING / ABRNORMAL BLEEDING
- ☐ ASAM / ASTHMA
- ☐ KANKER / CANCER
- ☐ EPILEPSIE / EPILEPSY
- ☐ VIGS / AIDS
- ☐ DIABETES
- ☐ GEHOORPROBLEME / HEARING IMPAIRMENT
- ☐ HARTGERUIS / HEART MURMUR
- ☐ RUMATIEKKOORS / RHEUMATIC FEVER
- ☐ TUBERKULOSE / TB

ENIGE ANDER MEDIESE PROBLEME / ANY OTHER MEDICAL PROBLEMS

DAMES: IS U SWANGER / LADIES: ARE YOU PREGNANT? ☐

HOEVEEL MAANDE / HOW MANY MONTHS? ☐

HET U ENIGE VAN DIE VOLGENDE GEWOONTES? / DO YOU HAVE ANY OF THESE HABITS?

- ☐ KNERS VAN TANDE / CLENCHING OR GRINDING TEETH
- ☐ LIPSUIG, LIPBY / LIP SUCKING, LIP BITING
- ☐ ASEMHAAL DEUR MOND / MOUTH BREATHER
- ☐ SPRAAKPROBLEME / SPEECH PROBLEMS
- ☐ DUIMSUIG / THUMB SUCKING
- ☐ NAELBYT / NAIL BITING

Ek bevestig dat die inligting wat ek verstrek het na die beste van my wete korrek is en verstaan dat dit as streng vertroulik hanteer sal word, en dat dit my verantwoordelikheid is om die praktyk van enige verandering in die pasiënt se gesondheid te verwittig. Ek magtig die tandheelkundige personeel om die tandheelkundige dienste wat die pasiënt te verskaf. Ek verstaan dat ek verantwoordelik is vir die betaling van enige dienste gelewer.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in confidence and it is my responsibility to inform this practice of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services the patient may need. I understand that I am responsible for payment of any sevices rendered.

HANDTEKENING / SIGNATURE _____ **VERWANTSKAP / RELATIVE** _____ **DATUM / DATE** _____

Consent for use of photos:

Patients under 18 years of age (must be signed by a parent / guardian):

I, _____ (parent/guardian) of _____ (patient full name) _____ (date of birth / id number) hereby grant unreserved permission for the usage of any photos which can include but are not limited to facial and / or intra-oral photos that are taken by Dr. P.D Ferreira or any of his employees during appointments and / or the treatment period and / or post treatment which may be posted on the website of or social media pages of the practice.

Adult patients (over 18 years of age - signed by patient):

I, _____ (patient full name) _____ (id number) hereby grant unreserved permission for the usage of any photos which can include but are not limited to facial and / or intra-oral photos that are taken by Dr. P.D Ferreira or any of his employees during appointments and / or the treatment period and / or post treatment which may be posted on the website or social media pages of the practice.