DR. CHALITA le ROUX
dentist & aesthetic practitioner

PATIENT DETAILS

- Surname.....
- First name.....
- Title.....
- Date of birth.....
- ID number.....
- Contact number.....

PERSON RESPONSIBLE FOR THE ACCOUNT

- Surname.....
- First name.....
- Title.....
- Home address.....
- Home tel / cell number.....
- Employer.....
- Work address.....
- Work tel number.....
- Postal address.....
- Email.....

MEDICAL AID DETAILS CONTACT

- Medical aid / Plan.....
- Dependent code.....
- Medical aid Number.....
- Main member.....
- Main member ID number.....

NEAREST FAMILY/EMERGENCYCONTACT

- Name .....
- Contact number .....

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HEALTH QUESTIONNAIRE

Do you have or have you had any of the following illnesses:

1. High/ low blood pressure
2. Angina
3. Rheumatic/scarlet fever
4. Congenital heart disease
5. Asthma/bronchitis/emphysema/TB
6. Jaundice/hepatitis/other liver disease
7. Kidney disease
8. Diabetes
9. Epilepsy
10. Bleeding tendency
11. Anemia
12. Arthritis
13. Muscular disease
14. Allergies …….
15.Other

……

Have you ever taken/ are currently taking any of the following medication

1. Cortisone/ other steroids
2. Anti-depressants
3. Tranquilizers/ sedatives
4. Anti-coagulants/ blood thinners
5. Blood pressure/ anti-hypertensives
6. Thyroid drugs
7. Contraceptives
8. Bisphosphonate treatment / Bone density
9. Other.....

Do you have any artificial prosthesis? (Heart valves/knees/hips) .....

Have you or any family member had any complications or unusual reactions to local/general anesthesia?.....

Female patients: are you pregnant/trying to get pregnant? .....

I declare that the above information is correct and that I shall make known any changes in my health to the treating practitioner. I further declare that the above mentioned address is the account holders permanent address. I accept full responsibility for my account. I give consent to be treated by the dentist after consultation and with my full understanding of the treatment plan and costs thereof. This is a legal and binding contract.

Signed at ……. on the …… of ……. 20…….

Signature: …… Name: ……

DR CHALITA le ROUX
dentist & aesthetic practitioner

Dear patient,

Please note:

This practice is contracted out of medical aid tariffs and requires IMMEDIATE payment for all services rendered.

You are kindly requested to settle your account straight after consultation.

Credit / debit cards, masterpass and cash accepted.

Settled accounts will be emailed to you in order for you to claim back from your medical aid.

Unfortunately we do not allow EFT's or month-end payments.

Pensioners, please enquire for special benefits.

Kind regards

Dr Chalita le Roux and team

DR CHALITA le ROUX
dentist & aesthetic practitioner
B.Ch.D (Pret) (Cum Laude)
Practice Number: 0992801

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e-mail: info@drchalitaleroux.co.za

Account Name: Dr Chalita le Roux INC
Bank Name: First National Bank
Account Number: 63018452796
Branch: 251141