DR JANEL WELGEMOED
DR MATTHYS DU TOIT
DR SIMONE MORKEL
DR JODY KALDENBERG
PRACTICE 5438926
021 785 4444

LONGBEACH DENTAL

PATIENT REGISTRATION FORM

Patient Details

Full Name: ..... Title: .....

ID Number: ..... Date of Birth: .....

Home address: .....

Email address: .....

Tel No(H) .....Tel No(W): ..... Cell: .....

Occupation: .....

Alternative Contact Name and Number

Full Name: ..... Title: .....

Contact number: .....Relationship: (Spouse/friend, etc.) .....

Reason for this visit? e.g., Pain, Check-up, Broken tooth .....

Are you interested in tooth whitening? .....

Are you interested in straight teeth? .....

Account Holder (Guarantor) or Medical Aid Main Member Details

Full Name: ..... Title: .....

ID Number: ..... Date of Birth: .....

Home address: .....

Email address: .....

Tel No (H): ..... Tel No (W): ..... Cell: .....

Medical Aid: ..... Membership Number: .....

FEE STRUCTURE AND PRACTICE POLICY:

1. All accounts are to be settled in full after each appointment
2. Longbeach Dental is not contracted to any Medical Aids
3. EFT Payments are to be done on the premises
4. Cheques, Diners Club and American Express cards are not accepted

Please tick YES or NO		
Do you give Longbeach Dental permission to send you SMS appointment reminders?	YES	NO
Do you give Longbeach Dental permission to send you SMS or email marketing information?	YES	NO

1. I CONFIRM THAT THE INFORMATION FURNISHED BY ME ABOVE IS TRUE AND CORRECT.
2. I CONFIRM THAT THE ACCOUNT IS TO BE SETTLED IN FULL AFTER EACH TREATMENT, AND THAT LONGBEACH DENTAL IS NOT CONTRACTED TO ANY MEDICAL AID.
3. I UNDERSTAND THAT THE DETAILS SUPPLIED BY ME, ON THIS FORM ARE PROTECTED IN TERMS OF THE POPI LEGISLATION.
4. MY DENTIST MAY HOWEVER USE ANY OF THE DETAILS PROVIDED ON THIS FORM TO PURSUE PAYMENT BY ME FOR UNPAID ACCOUNTS FOR WHATEVER REASON I ALSO AGREE THAT IN THE EVENT OF NON-PAYMENT.
5. I AUTHORISE MY DENTIST TO DESTROY RECORDS IF THEY HAVE BEEN INACTIVE FOR LONGER THAN 6 YEARS.
6. I AUTHORISE MY DENTIST TO PROVIDE MY MEDICAL AID WITH MY PERSONAL MEDICAL DATA.
7. I AUTHORIZE MY DENTIST TO PROVIDE MY MEDICAL HISTORY TO ANY REFERRAL SPESIALIST, IF NECESSARY.

Signature: ..... **Date** .....