



McGyver Dental 24 (Pty) Ltd.

Dr. Riana Moolman
B.Ch.D. (UWC)
Pr Nr: 0582220

31 Cornwell Street, Oakdale
Bellville, 7530
(021) 948 8469



PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Title: Mr. / Ms. / Mrs. / Mx. / Dr. / Prof. Initials:

Surname:

First Name:

ID nr. :

D.O.B. YYYY/MM/DD

Physical Address:

.....Code:

Email:

Cell nr:

Tel nr:

Work Tel nr:

Occupation:

Employer:

Home Language:

Referred by:

PATIENT INFORMATION

Title: Mr. / Ms. / Mrs. / Mx. / Dr. / Prof. Initials:

Surname:

First Name:

ID nr. :

D.O.B. YYYY/MM/DD

Physical Address:

.....Code:

Email:

Cell nr:

Tel nr:

Work Tel nr:

Occupation:

Employer:

Home Language:

Referred by:

PLEASE NOTE THAT YOU, AND NOT YOUR MEDICAL AID, WILL BE RESPONSIBLE FOR THE PAYMENT OF THE ACCOUNT.

We are a fee - for- service practice and payment is due immediately after each appointment.

MEDICAL AID DETAILS

Medical Aid:

Plan:

Membership Nr:

TERMS AND CONDITIONS

The patient agrees to pay the Medical Practice of Dr Riana Moolman (hereafter "MP") for services rendered at the tariff charged by MP from time to time. All accounts will be payable within 30 day of the invoice date. Interest on arrears balances shall accrue at a rate of 24% per annum compounded monthly and calculated in arrears. Should the patient fail to pay the account and MP decides to commence with legal proceedings, the patient undertakes to pay all legal costs relating to the recovery of the outstanding monies in respect of professional services rendered, including attorney fees on an attorney own client scale, collection commission and tracing costs.

The person responsible for paying the account (hereafter "RP"), binds himself as surety for and co-principal debtor jointly and severally with the patient to MP for the due performance by the patient of the obligations owing by him to MP in terms of this contract. The RP waives and renounces (1) any right to claim an accounting from the Creditor before making payment (2) any benefits which the MP as surety is entitled to in law, without detracting from the generality of the afore going, including the benefits of excussion, division, cession of action and being sued together.

The patient and RP hereby authorise MP to receive, share and exchange credit information concerning them with any credit bureau or any other person or corporation with whom they have or may have financial dealings including, where applicable, information requested pursuant to, or in any circumstance contemplated in the National Credit Act 34 of 2005.

The patient and RP choose the physical addresses as described above as their domicillium citandi et executandi for the purpose of legal proceedings and undertake to notify MP in writing of any change to their domicilium addresses. The signatories warrant that the terms and conditions of the contract have been read and understood and are agreed to and the contract is entered into on such terms and conditions.

Signed at **BELLVILLE** on this the (Day) of (Month) 20..... (Year)

.....
Signature (Person Responsible for Payment of Account)

PATIENT HEALTH QUESTIONNAIRE

NOTE: The information requested on this form is confidential. It is used to evaluate your dental needs and to aid in proper treatment.

Do you have or had any of the following health problems? Mark with [X].

Anaemia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
Arthritis / Rheumatism	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Porphyria	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	Headaches (Chronic)	<input type="checkbox"/>	Profuse Bleeding	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>
Back / Neck Problems	<input type="checkbox"/>	Heart Problems / Attack	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	Haemophilia	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Stent	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Clotting Disorders	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Swelling of Feet / Ankles	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Dizziness / Fainting	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Tumours	<input type="checkbox"/>
If Other, Please Specify	<input type="checkbox"/>				

MEDICATIONS

List of medications you are currently taking:

ALLERGIES

Aspirin	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	Sulphur	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Local Anaesthetic	<input type="checkbox"/>	Iodine	<input type="checkbox"/>
Acrylic	<input type="checkbox"/>	Metal	<input type="checkbox"/>
If Other, Please Specify	<input type="checkbox"/>		

OTHER

WOMEN	If Yes – Please Specify
Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you breastfeeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
GENERAL	
Have you experienced any unfavourable reaction to dental treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you a smoker? Current or Past?	Yes <input type="checkbox"/> No <input type="checkbox"/>

EMERGENCY CONTACT LIST

Name of General Practitioner	Name of Friend / Family Member
Contact Number	Contact Number

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the dental office of any changes in my (or the patient's) in medical status.

Signed at **BELLVILLE** on this the (Day) of (Month) 20..... (Year)

.....
Signature (Patient) or (Legal Guardian / Parent of Patient)

INFORMED CONSENT PROVIDED BY PATIENT /PARENT /GUARDIAN IN TERMS OF
THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA) FOR
PERSONAL INFORMATION TO BE COLLECTED AND PROCESSED BY
McGyver Dental 24 (Pty) Ltd.
("the responsible party", "practice" and also "the company")

CONSENT FOR THE PROCESSING AND USE OF PERSONAL INFORMATION

I, the undersigned an adult person (18 years or older) / the parent or legal guardian of a child hereby consent to the processing of my personal information or that of my child as contemplated in the Protection of Personal Information Act No 4 of 2013, by the practice, the practice staff and third party with whom the practice has a contractual relationship for the following purposes:

- [a] for the purposes of identifying and / or verifying the Patient's or dependent's details;
- [b] treating and managing me and/or my child in terms of a dentist-and-patient relationship;
- [c] for further processing or the administration of the contractual relationship between myself and the practice;
- [d] for legal or contractual purposes;
- [e] communicating with other persons in as much as it relates to my treatment and management;
- [f] communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof including medical schemes and their administrators where relevant;
- [g] for the purposes of recovering unpaid monies and / or any other amount due to the practice;
- [h] for the purpose of debt collection;
- [i] for the purposes of identify other products and services which might be of interest to the Patients;
- [j] for the purposes of informing Patients about the practice's products and services.
- [k] processing is necessary for pursuing the legitimate interest of the practice or the third party to whom the information is supplied.

Withholding Consent. I understand that it the policy of the practice to require all patients complete and sign the consent. If I exercise my right to withhold my consent to the practice collecting and processing Personal Information, I understand and agree that in this case, the practice reserves the right not to provide dental services (except emergencies) and for which I take full responsibility and indemnify the Practice.

Withdrawal. I understand that I can withdraw this consent at any time and I undertake to inform the practice of my withdrawal. In this case, I understand that this may affect my rights and contractual relationship that I have with the practice and for which I take full liability and hereby indemnify the practice.

My consent is provided of my own free will without any undue influence from any person whatsoever. I confirm that I have permission of my dependant(s) to give their consent, where such consent has been provided and I indemnify the practice against this.

The Practice Information Officer details are: **Dr. Riana Moolman**

PATIENT SIGNATURE

PRINT NAME

DATE

Cell nr: _____ E-mail address: _____



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INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You, the patient has the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. _____ Please Initial

2. DRUGS, MEDICATION, AND SEDATION

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. _____ Please Initial

3. NEEDLE STICK INJURY

I understand that if someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis. _____ Please Initial

4. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures found while working on teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary, with my consent. _____ Please Initial

5. FILLINGS AND RESTORATIONS

I understand the need for fillings to replace tooth structure lost due to decay. I understand that in time, fillings need to be replaced due to wear and staining of the resin material. I understand that if decay extends very deep, a change in procedure will be needed (e.g., Root Canal Treatment or Extraction). I understand that care must be exercised in chewing on the new filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling. _____ Please Initial

6. REMOVAL OF TEETH (EXTRACTION)

An alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the affected tooth (teeth) and any others necessary for the reasons in paragraph #4. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, sinus perforation, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paraesthesia) that can last for a period of time or a fractured jaw. I understand that there might be a residual bone spicule or root fragment left when complete removal would require extensive surgery and unnecessary complications. I understand that after an extraction, there may be stiffness of facial and neck muscles, a change in bite or possible TMJ joint difficulties. I also understand that bad infections take a while to clear up. I understand that smoking and alcohol use after an extraction can delay the healing process. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, and that the cost of which is my responsibility.

_____ Please Initial

7. CROWNS, BRIDGES, VENEERS, AND BONDING

I understand that sometimes it is not possible to match the colour of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or veneer (including shape, fit, size, placement, and colour) will be done before cementation. It explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. I understand new decay at the edges of the crown is possible if I do not maintain my oral hygiene.

_____ Please Initial

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic and/or metal.

The potential problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage due to tissue shrinkage. I understand partial clasps can wear out the natural teeth, can rock or cause stress to my own teeth. The metal clasps are sometimes visible and decay can occur under the clasps if I do not maintain my oral hygiene. There is always some movement under a denture. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and colour) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after. The cost of this procedure is not in the initial denture fee. I understand dentures need to be replaced every 3 -5 years due to changes in your jaws (e.g., bone resorption and gum recession).

_____ Please Initial

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally posts are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). The purpose of the Root Canal Therapy has been explained to me, as well as alternative treatments. I have been informed that following the treatment, a crown may be needed to improve the prognosis due to loss of tooth structure. I have been made aware that an undiagnosable root fracture or a secondary canal means failure and extraction. Post treatment swelling and pain may be around for several days after treatment. Infection can continue. Breakage of a Root Canal instrument which may or may not be left in the canal, (per the Doctor's judgment), may require additional oral surgery to retrieve.

_____ Please Initial

I HAVE READ THE ABOVE STATEMENTS AND A COPY IS AVAILABLE TO ME UPON REQUEST.

MY INITIALS INDICATE THAT I HAVE READ AND UNDERSTAND THIS CONSENT DOCUMENT. I UNDERSTAND THERE IS NO ABSOLUTE GUARANTEE OR ASSURANCE CAN BE GIVEN WITH THE PROPOSED TREATMENT. I ALSO UNDERSTAND THAT MY COOPERATION WITH THE RECOMMENDATIONS AND REQUESTS BY THE DENTIST IS VERY IMPORTANT. THE LACK OF SAME WILL RESULT IN LESS THAN OPTIMUM RESULTS AND SATISFACTION. IF FOR ANY REASON A CONFLICT ARISES, I WILL FIRST PRESENT SUCH CONFLICT OR DISAGREEMENT TO THE DENTIST, IN ORDER TO RESOLVE THE PROBLEM.

I NOW GIVE MY CONSENT, TO THE DENTIST, TO RENDER TO ME THE DENTAL TREATMENT THAT WE HAVE COLLECTIVELY AGREED UPON AS NECESSARY FOR MY ORAL HEALTH AND WELLBEING. I FURTHER AGREE TO REIMBURSE THE DENTIST FOR ALL SERVICES RENDERED TO ME. I AM AWARE THAT FULL PAYMENT FOR THESE SERVICES IS DUE AT THE TIME THEY ARE RENDERED.

PATIENT SIGNATURE

PRINT NAME

DATE

DOCTOR SIGNATURE

PRINT NAME

DATE