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: .....

THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA) CONSENT

McGyver Dental 24 (Pty) Ltd. (hereafter referred to as "the practice") is required to protect your personal information as regulated by the POPI act 4 of 2013. The act is there to protect your personal information, entrusted to the practice by you (hereafter referred to as "the patient") from unauthorised modification, destruction or access by any unauthorised persons.

- Your personal information and dental records are stored digitally and on paper at this practice.
- The patient will firstly be informed, if a request has been made for your personal information or dental records from a 3rd party (Medical Aid Provider, Specialist, Physician etc.). The reason for requiring access to the information by the 3rd party will be clearly stated to you.
- Consent to disclose any confidential information will be obtained in written or verbal format from the patient by the practice before any disclosures are made or access to information is given to a 3rd party.
- The practice requires all patients to sign this consent.
- The patient can withhold consent and the practice reserves the right not to provide dental services.
- The patient can withdraw this consent.

I, hereby give McGyver Dental 24 (Pty) Ltd. consent to process my personal information as per the POPI ACT 4 OF 2013.

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

.....

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

PATIENT HEALTH QUESTIONAIRE

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

MEDICATIONS

List of medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

Aspirin	☐	Penicillin	☐
Barbiturates	☐	Sulphur	☐
Codeine	☐	Latex	☐
Local Anaesthetic	☐	Iodine	☐
Acrylic	☐	Metal	☐
If Other, Please Specify	☐		

OTHER

WOMEN			If Yes – Please Specify
Are you pregnant?	Yes	No	
Are you breastfeeding?	Yes	No	
GENERAL			
Have you experienced any unfavourable reaction to dental treatment?	Yes	No	
Are you a smoker? Current or Past?	Yes	No	

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)

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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

TURN PAGE

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 THAT 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**