MATHEE
DENTAL STUDIO

www.matheedentalstudio.co.za
021 851 0461

Date:_____
____

New Patient Information

About You

Title: _____ Name: _____Surname: _____ Language: _____
H Phone: _____W Phone: _____Cell Phone: _____
Email: _____ ID: _____
Address: _____
City: _____Code: _____Profession: _____

Person Responsible for account if Other than Patient

First Name: _____Middle Name: _____Surname: _____
H Phone: _____ W Phone: _____Cell Phone:_____
Email:_____DOB:_____ID:_____
Address:_____
City:_____Code:_____Profession:_____

Insurance Information:

Medical Aid Name: _____Medical Aid Number: _____
Plan: _____Main Member: _____

Next of Kin:

Name: _____ Address: _____ Phone nr: _____

Medical History

GP's Name: _____Phone no:_____

Do you or have you experienced any of the following? (Tick if applicable)

Abnormal Bleeding	Anaemia	Artificial Bones/Joints
Artificial Valves	Asthma	Angina
Breathing Problems	Cancer	Cold sore/Fever Blisters
Diabetes	Depressive Illness	Emphysema
Epilepsy/Seizures	Fainting Spells	Glaucoma
Headaches	Heart Disorder	Hay fever
Haemophilia	Hepatitis	Herpes
High Blood Pressure	HIV+/AIDS	Kidney Problems
Lung Disease	Liver Disease	Lupus
Osteoporosis	Pacemaker	Pain in Jaw Joints
Rheumatic Fever	Seizures	Sinus Trouble
Stomach/Intestinal Disease	Stroke	Tobacco Use (Smoke)
Tuberculosis (TB)	Tumours	Ulcers

- Please list any serious medical condition(s) that you have experienced:
  _____
  _____
- Please list any medications you are currently taking:
  _____
  _____

- Any Allergies that you are awar _____
- **For Women**: Are you Pregnant? Week#: _____
- **Where did you hear about us**? _____

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PAYMENT POLICY

Private

Full payment is required on the day of each treatment.

If we do not receive your payment within 7 days, an admin fee of R50.00 will be charged with a further R15 penalty per month. Interest Charges are calculated at a rate of 1.5% every 30days (annual rate of 18%) based upon an unpaid balance outstanding 30days or more as of the billing date. Accounts that are not settled within 90 days, will be handed over for legal collection.

Payment options:

Cash, Credit Card, Debit Card or an Internet transfer before your appointment.

If an Internet transfer is made, please send your proof of payment to: smile@matheedentalstudio.co.za before the appointment.

Mathee Dental Studio's banking details are: Absa Private Bank Stellenbosch, Current Account No: 4091009473, Branch Code: 632005

Medical aid

We can handle the claim on your behalf providing that:

1. **You are an active member of the medical aid**
2. **You can provide us with a Medical Aid card and ID at least 24 hours before the appointment.**
3. **There are funds available for Dentistry or Dental cover on your medical Aid.**
4. **You agree to pay all patient portions within 7days after receiving a statement from us. If we do not receive your payment within 7 days, an admin fee of R50.00 will be charged with a further R15 penalty per month. Interest Charges are calculated at a rate of 1.5% every 30days (annual rate of 18%) based upon an unpaid balance outstanding 30days or more as of the billing date. Accounts that are not settled within 90 days, will be handed over for legal collection.**
5. **You understand that we treat you according to the treatment you need and not according to medical scheme cover. You will be responsible for codes not covered by your medical aid.**
6. **We do not handle claims for Orthodontic treatment.**
7. **You are responsible to get pre-authorisation from your medical aid for all treatment that needs pre-authorisation.**

Payment options are the same as above:

<u>Terms and Conditions in terms of handing over an account.</u>

- **The patient and/or guarantor consents that the practice may use a national Credit Bureau for tracing purposes if necessary.**
- **Should the patient or guarantor fail to settle their account in full, the practice may proceed with listing the patient and/or guarantor at the Credit Bureau**
- **In the event of legal proceedings for the recovery of an unpaid account, the patient and/or guarantor will be liable for the payment of legal fees at a rate between Attorney and own client. All parties named herein consent to the jurisdiction of the magistrate's court should legal Proceedings be necessary for collection of outstanding amounts.**

If you accept all the above, kindly sign below.

Please tick:

May we please use pictures of your teeth for marketing on our website or social media?

I read the Privacy Policy on your website.

I have read and accept the Payment Policy above.

SIGN

_____ _____

Signature: Patient / Main Member: **Full name:** **Date:**

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