Dr Johan Baard
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Orthodontist/Ortodontis
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PATIENT DETAILS: Male ☐ Female ☐ Language preference: English ☐ Afrikaans ☐

Title: Dr/Mr/Mrs/Miss/Ms/Other _____ Surname: _____

Full Names: _____ Date of Birth: _____ Age: _____

Who referred you? _____ Your dentist (Name): Dr _____

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT:

Title: _____ Initials: _____ Surname: _____ First name: _____

ID Number: _____ Marital Status: _____

Postal address:

_____

_____

_____ Code: _____

The person responsible for the account chooses *domicilium citandi et executandi* at the abovementioned home address for the purpose of service of all processes and notices, which address may be changed by a 7 day written notice by registered post.

MEDICAL AID DETAILS:

Scheme: _____ Plan: _____ Membership number: _____

Joining date: _____ Principal member name: _____

Dependant no: _____

NB – You are responsible to submit the account to your medical aid as we do not deal with medical aids. We do charge medical aid rates to approved patients but you as patient / parent remains responsible for the account until settled.

_____ _____ _____

Please print name of person completing this form **Signature** **Date**