Dr Johan Baard
BChD, Dip Odont, MChD (Pret)
186A JOUBERT STREET
RUSTENBERG

Orthodontist/Ortodontis

Practice No. 064 000 0322458

TEL: 014 592 6941 • FAX: 014 592 6939
E-MAIL: johan.baard@ionline.co.za

PATIENT DETAILS: *(Additional Information)*

Normally called: _____ Surname: _____

Main complaint: _____

Have you had previous orthodontic treatment? No ☐ Yes ☐ Dr _____

School: _____ Grade: _____

RELEVANT MEDICAL HISTORY _____
(Allergies, Heart problems, Rheumatic Fever history, Diabetes, Current medication, etc.)
Tonsils / adenoids still present ☐ removed ☐
Are you currently pregnant or contemplating pregnancy: No ☐ Yes ☐

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT: *(Additional Information)*

Occupation: _____ Employer: _____

Work address: Home address:

_____ _____

_____ _____

_____ Code _____ _____ 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.

Work Tel: _____ Home Tel: _____ Cell: _____

Fax: _____ e-mail: _____ Cell spouse: _____

Next of Kin: (not at the same address and telephone number) Relationship: _____

Name and Surname: _____ Occupation: _____

Employer: _____

Address of employer: _____

Tel number: _____ Cell: _____

_____

_____ _____ _____

Please print name of person completing this form Signature Date

AUTHORISATION / MAGTIGING

I
Ek, _____
(PARENT – FULL NAME) (OUER – VOLLE NAME)

Identity number :
Identiteitsnommer : _____

Herewith give permission for Dr Baard to continue with the treatment of:
Gee hiermee toestemming dat Dr Baard mag voortgaan met die behandeling van:

_____
(PATIENT'S NAME) (PASIËNT SE VOLLE NAAM)

and I take responsibility for any costs not covered by the Medical Aid Fund / Health Care Provider Fund.
en verklaar dat ek verantwoordelikheid neem vir enige kostes wat nie deur die Mediese Fonds betaal word nie.

PHYSICAL ADDRESS - NOT A PO BOX *(Domicilium citandi et executandi)*
FISIESE ADRES - NIE 'N POSBUS NIE *(Domicilium citandi et executandi)*

_____

_____

_____

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 may be changed by a 7 day written notice by registered post.

Die person verantwoordelik vir die rekening kies *domicilium citandi et executandi* vir doeleindes vir die betokening van prosesstukke en kennisgewings, by bogenoemde woonadres, wat verander kan word deur 7 dae kennisgewing by wyse van aangetekende pos.

_____ _____
PARENTS' SIGNATURE / HANDTEKENING VAN OUERS DATE / DATUM

_____
NAME IN PRINT / NAAM IN DRUKSKRIF

RETURN FULLY COMPLETED AND SIGNED TO THE PRACTICE
BESORG TEN VOLLE INGEVUL EN GETEKEN TERUG AAN DIE PRAKTYK
Dr Johan Baard – for attention – accounts / vir aandag – rekeninge