FOUCHE
ORTHODONTICS

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FOUCHE ORTHODONTICS NEW PATIENT FORM

PATIENT INFORMATION / PASIËNT BESONDERHEDE

Preferred Name / Noemnaam: _____ Surname / Van: _____

Full Names / Volle Name: _____

ID No / ID Nr: _____ Patient Sex / Pasiënt Geslag: _____

Age / Ouderdom: _____ Patient Date of Birth: _____

Medical Alert / Mediese Waarskuwing: _____ Language / Taal: ☐ English ☐ Afrikaans

Patient Cell Nr: _____ Patient's Dentist / Jou Tandarts: _____

CONTACT PERSON FOR APPOINTMENTS / KONTAKPERSOON VIR AFSPRAKE

Name / Naam: _____ Relationship / Verwantskap : _____

Cell No / Sel Nr: _____ Alternative Contact Nr / Alternatiewe kontaknr: _____

Email Address / Epos Adres: _____

MEDICAL AID DETAILS / MEDIESE FONDS BESONDERHEDE

Medical Aid Name / Fondsnaam: _____ Medical Aid Option /Fondsplan: _____

Medical Aid No / Fondsnr: _____ Dependent Code / Afhanklike Kode: _____

PERSON RESPONSIBLE FOR ACCOUNT / PERSOON VERANTWOORDELIK VIR REKENING

Surname / Van: _____ Initials / Voorletters: _____

Full Names / Volle Name: _____ Title / Titel: _____

ID No / ID Nr: _____ Relation to Patient / Verwantskap aan Pasiënt: _____

Residential Address / Woonadres: _____ Code / Kode: _____

Postal Address / Posadres: _____ Code / Kode: _____

Home Tel No / Huis Tel Nr: _____ Cell No / Sel Nr: _____

Email Address / Epos Adres: _____

Marital Status: _____ Occupation / Beroep: _____

Werkgewer Tel No / Werkgewer Tel Nr: _____ Employer / Werkgewer: _____

NEXT OF KIN NOT LIVING WITH YOU / NAASBESTAANDE WAT NIE IN DIESELFDE HUIS WOON NIE

Name / Naam: _____ Surname / Van: _____

Cell Nr / Sel Nr: _____

Alternative Contact Nr / Alternatiewe Kontaknr: _____

INITIAL

DENTAL HISTORY OF PATIENT / TANDHEELKUNDIGE GESKIEDENIS VAN PASIËNT

What is your main dental concern? / Wat is die rede vir jou besoek? _____

Did you have orthodontic treatment before?/Het jy voorheen ortodontiese behandeling gehad? _____

Are you enquiring for a second opinion? / Is die rede vir jou besoek 'n tweede opinie? _____

Do you have any of the following habits or problems? / Het jy enige van die volgende gewoontes of probleme?

- ☐ Clenching or Grinding Teeth / Kners van Tande
- ☐ Lip Sucking, Lip Biting / Lipsuig, Lipbyt
- ☐ Mouth Breather / Asemhaal deur Mond
- ☐ Speech Problems / Spraakprobleme
- ☐ Thumb Sucking / Duimsuig
- ☐ Nail Biting / Naelbyt
- ☐ Were any of the milk teeth extracted at an early age? / Is van u melktande op 'n vroeër ouderdom getrek?
- ☐ Have you had any jaw or facial surgery? / Het u al chirurgie aan u kake of gesig gehad?
- ☐ Have you had any trauma to your teeth? / Het u al enige beserings aan u tande gehad?
- ☐ Is there a family history of orthodontic problems? / Is daar 'n familiegeskiedenis van ortodontiese probleme?
- ☐ Have you had your tonsils or adenoids removed? / Is u mangels of adenoïdes al verwyder?

MEDICAL HISTORY OF THE PATIENT / MEDIESE GESKIEDENIS VAN DIE PASIËNT

Smoking? / Rook u? ☐ No / Nee ☐ Yes / Ja

Pregnant? / Swanger? ☐ No / Nee ☐ Yes / Ja How many months? / Hoeveel maande? _____

Did you or do you have any of the following conditions? / Is jy tans of voorheen met enige van die volgende toestande gediagnoseer?

- ☐ Allergies / Allergieë Please specify / Spesifiseer asseblief _____
- ☐ Rheumatic Fever / Rumatiekkoors
- ☐ Hearing Impairment / Gehoorprobleme
- ☐ Heart Disease / Hartkwaal
- ☐ High or Low Blood Pressure / Hoë of Lae Bloeddruk
- ☐ Prolonged Bleeding / Bloeier
- ☐ Jaundice (Hepatitis) / Geelsug
- ☐ Diabetes / Suikersiekte
- ☐ Cancer / Kanker
- ☐ HIV Aids / MIV Vigs
- ☐ TB / Tuberkulose
- ☐ Epilepsy / Epilepsie
- ☐ Muscle Disorder / Spierdisfunksie

Any other health problems not mentioned above? / Enige ander gesondheidsprobleme nie hierbo genoem nie?

☐ No / Nee ☐ Yes / Ja Please specify / Spesifiseer asseblief _____

Medication? / Medikasie?

☐ No / Nee ☐ Yes / Ja Please specify / Spesifiseer asseblief _____

Contact Details of Patient's Medical Practitioner / Kontakbesonderhede van Pasiënt se Mediese Praktisyn

Dr Name / Dr Naam: _____ Dr Tel No / Dr Tel Nr: _____

I hereby confirm that the information I supplied above is true and accurate, and I am responsible for any false information provided. I also confirm that I am aware that Fouche Orthodontics charge Discovery B Rates and that I am responsible to settle my full account within 30 days from the consultation date.

Patient / Parent / Guardian Signature:
Pasiënt / Ouer / Voog Handtekening: _____

Date:
Datum: _____