Dental Studios

Preserving Smiles

Centre for Preventative Dentistry

Dr. Uwe Esdar
Dentist / Tandarts / Zahnarzt

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Emergency +27 21 7021245

Rose Avenue Studio
16 Rose Avenue
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7945
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Patient Details

All information will be treated in the strictest of confidence.

Title: ┐ Prof. ┐ Dr. ┐ Rev. ┐ Mr.┐ Mrs. ┐ Ms. ┐ Miss. ┐ Mast.	
Surname:	First Name:
Date of Birth:	I.D. Number:
Resident of RSA: ┐ Yes ┐ No	Passport Number:
Residential Address:	Postal Address:
Cell:	
Tel. No. (Home)	Tel. No. (Work)
Fax No.:	E-mail address:
Home Language:	Preferred Language:
Marriage Status:	Dependants:
Occupation:	Company:
Name of Employer:	Employer's contact number:

Person Responsible for the account (If different from above)

Title: ┐ Prof. ┐ Dr. ┐ Rev. ┐ Mr.┐ Mrs. ┐ Ms. ┐ Miss. ┐ Mast.	
Surname:	First Name:
Date of Birth:	I.D. Number:
Resident of RSA: ┐ Yes ┐ No	Passport Number:
Residential Address:	Postal Address:
Cell:	
Tel. No. (Home)	Tel. No. (Work)
Fax No.:	E-mail address:

Occupation:	Company:
Name of Employer:	Employer's contact number

Medical Aid:

Medical Aid Name:
Medical Aid Number:
Principal Member:

Next of Kin:

Name of Family Member/ friend (not living in same house):	
Address:	
Cell:	E-mail:
Tel. No. (Home):	Tel. No. (Work):

Referred by:

First Name:	Surname:
Address:	Tel. No.:
	Cell:
	E-mail:

Financial Note:

This is a private practice and has no contracts with any medical aids or government health schemes.
This practice does not limit itself to the NHRPL fee or any other medical aid fee structures.

Payment is always due after each appointment.

On signing this you accept responsibility for payment of all dental services rendered.
Interest is chargeable on overdue accounts. This is agreed at 1.25% per month on balances over 30days.
You are responsible for all legal fees should the account be handed over for collection.
Please submit your paid up statement to your medical aid for reimbursement.

I accept and understand the conditions herein.

I, _____________________________________understand and accept the above conditions and also the

above information to be true.

______________________________ ______________________________

Patient Signature Date