DR RAEL POLAKOW

SPECIALIST MAXILLO-FACIAL AND ORAL SURGEON

FILE NR. _____

PATIENT DETAILS		
TITLE (Mr, Ms, other)	FIRST NAMES	SURNAME
DATE OF BIRTH	I.D.NUMBER	OCCUPATION
REFERRED BY	FAMILY DOCTOR	EMPLOYER
HOME ADDRESS	WORK ADDRESS	WORK TEL NR.
		CELL NO.
		HOME TEL NR.

ACCOUNT HOLDER'S DETAILS		
TITLE (Mr, Ms, other)	FIRST NAMES	SURNAME
RELATIONSHIP TO PATIENT	EMPLOYER	
POSTAL ADDRESS – ACCOUNTS	WORK ADDRESS	WORK TEL NR.
		CELL NR.
		HOME TEL NR.
MEDICAL AID NAME	MEDICAL AID NUMBER	I.D. NUMBER

DETAILS OF NEXT OF KIN NOT LIVING WITH YOU	
NAME	
ADDRESS	
RELATIONSHIP TO PATIENT	
WORK TEL NR.	HOME TEL NR.

MEDIC ALERT

HEALTH QUESTIONNAIRE **CONFIDENTIAL**

We are concerned about your health. Your general health may be influenced by surgical treatment. Please answer this questionnaire as clearly and fully as you can. Thank you. **PLEASE PRINT IN CAPITAL LETTERS**

How would you describe your present health?

GOOD		FAIR		POOR	

Are you being treated by a specialist (e.g. physician, surgeon?) YES / NO
If YES, please detail : _____
Have you ever had any surgical operation or slept in hospital for any reason? YES/NO
If YES, please detail: _____

Indicate any of the following which you may have or have had with an X

CENTRAL NERVOUS SYSTEM

Stroke		Epilepsy	

HEART AND VASCULAR CONDITIONS

Congenital Heart Lesions		Rheumatic Fever	
Valve Prosthesis		Heart murmur	
Cardiac pacemaker		Heart Attack	
High Blood pressure		Low Blood Pressure	
Blood Clotting Disorders		Bleeding Tendency	

LUNG CONDITIONS

Asthma		Night Sweats		Tuberculosis	

GASTRO-INTESTINAL SYSTEM

Stomach Ulcers		Hepatitis / Jaundice	

MISCELLANEOUS

Diabetes		Thyroid Disease	
Porphyria		Kidney Disease	

OTHER – Do you have any disease, condition or problem not listed above you feel we should know about? Please detail: _____
MEDICINE / TABLETS – Are you taking any medicines at present? YES /NO
If yes, please list these: _____
Apart from these, have you ever taken any of the following in the past?

Antidepressants: Name:	Cortisone: Name:
Tranquilisers: Name:	Blood thinners: Name:

ALLERGIES – Please name any medicines or drugs to which you are allergic: _____
MEDIC ALERT - Are you a member ? YES / NO
WOMAN PATIENTS – Are you pregnant? YES / NO Are you on the pill? YES / NO

Please Note:
In order for you to consider the fees we are quoting, you need to be aware of the background determining fees, so that you do not confuse the "medical aid benefit" with the fee we are quoting you for your treatment.
The Department of Health issues an annual National Reference Price List (NRPL), which is intended to be a list of reference prices that medical aid schemes use as a baseline to determine the benefits for members and in most cases does not reflect the actual cost of providing such a service.
In order to provide a quality dental service to our patients, this practice is unable to operate at those "medical aid rates" and we have now based our fees on the "ethical tariffs" determined by the Health Professions Council of South Africa [HPCSA] The fees charged in this practice are determined by the quality and standard of the treatment rendered. This practice does not enter into negotiations with any "Medical Aid" organisation or third party funder. Patients are responsible for settling the account after each treatment.

Signature: _____ Date: _____