All Smiles
DENTAL CLINIC

DR LYNDEN STERLEY
B.Ch.D, PDD

PATIENT DETAILS

TITLE (PLEASE CIRCLE) MR MAST MRS MISS DR PROF REV

NAME ..... SURNAME .....

E-MAIL ..... CONTACT NR .....

DATE OF BIRTH (DD/MM/YY) .....

ID NUMBER .....

CONTACT DETAILS (PERSON RESPONSIBLE FOR ACCOUNT)

NAME ..... SURNAME .....

E-MAIL .....

CELL .....

HOME ..... WORK .....

HOME ADRESS ..... POST CODE .....

ID NUMBER .....

MEDICAL AID DETAILS

NAME OF FUND .....

MAIN MEMBER .....

MEDICAL AID NUMBER .....

CONTACT PERSON (NOT FAMILY MEMBER)

NAME AND SURNAME .....

CONTACT NUMBER .....

Are you allergic to any medication? .....

Are you currently taking any medication? Please specify .....

021 887 2422
A/H 083 263 7938

UNIT 203, DE JONKER CENTRE
MORKEL STREET, STELLENBOSCH 7600

dentistry@allsmiles.co.za
www.allsmiles.co.za

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All Smiles Dental Clinic does not submit any accounts to the medical aids.
Payment must be made immediately after the consultation. A detailed statement will be sent to you in order to claim from your medical aid. For your convenience we have debit and credit card facilities. The account is the responsibility of the patient, and in regards to minors, the parent/guardian is responsible therefore.

I understand the terms and conditions and I undersign to pay the account on the day of the consultation. I understand that should I fail to pay the account, I will be held liable for all fees incurred to recover monies owed.

Signature Date

All Smiles Dental Clinic stuur geen rekeninge na mediese fondse nie.
Betalings moet asseblief na die afloop van die konsultasie vereffen word.
'n Volledige state sal aan u gegee/gestuur word sodat u die rekening van u medies kan eis.
Vir u gerief het ons krediet- en debietkaart fasiliteite.
Die rekening bly die verantwoordelikheid van die pasient, en in die geval van 'n minderjarige, die ouer of voog. Ek neem kennis van hierdie voorwaardes, en onderteken om die rekening te vereffen op die dag van die konsultasie.

Handtekening Datum

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