PHEIFFER Endodontics

Patient Information Form

Details of Main Member on Medical Aid or Responsible for Account Person

Name *

Prefix | First Name | Last Name

ID Number *

Contact Number *

Alternative Contact Number

E-mail *

example@example.com

Address: *

Street Address

Street Address Line 2

City County

Postal Code

Please select one of the following options: *

- I am a Private Patient
- I have a Medical Aid

Medical Aid Details

If Applicable

Details of Patient (If different from above)

Name

First Name Last Name

Date of Birth

Day Month Year

ID Number *

Contact Number

Dependent code/number

Medical History of Patient

Are you a smoker? *

- ☐ Yes
- ☐ No

Are you Allergic to anything? *

- ☐ Yes
- ☐ No

If yes, please list you allergies here:

Do you make use of any opioids, methamphetamine or cannabis? *

- ☐ Yes
- ☐ No

Do you have any medical conditions? *

- ☐ Yes
- ☐ No

If yes, please list the medical conditions here:

Are you currently taking any medications? *

- [ ] Yes
- [ ] No

If yes, please list all medications here:

In case of Emergency

Emergency Contact: *

First Name Last Name

Relationship *

Emergency Contact Number *

Payment Agreement

*

- [ ] I hereby acknowledge that I am fully responsible for payment of my account. All treatment costs are payable directly after every appointment. Please see www.drstefan.co.za for more details

Protection of Personal Information Consent

Informed consent provided by

Please Select

IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA)
FOR PERSONAL INFORMATION TO BE COLLECTED AND PROCESSED BY
DR STÉFAN PHEIFFER
("the responsible party", "practice" and also "the company")

CONSENT FOR THE PROCESSING AND USE OF PERSONAL INFORMATION

I, the undersigned an adult person (18 years or older)/**the parent or legal guardian of a child younger than 12 years of age/ a child 12 years or older hereby consent to the processing of my personal information or that of my child as contemplated in the Protection of Personal Information Act No 4 of 2013, by the practice, the practice staff and third party with whom the practice has a contractual relationship for the following purposes:

a) for the purposes of identifying and/or verifying the Patient's or dependent's details;
b) treating and managing me and/or my child in terms of a dentist-and-patient relationship;
c) for further processing or the administration of the contractual relationship between myself and the practice;
d) for legal or contractual purposes;
e) communicating with other persons inasmuch as it relates to my treatment and management;
f) communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof including medical schemes and their administrators where relevant
g) for the purposes of recovering unpaid monies and/or any other amount due to the practice;
h) for the purpose of debt collection;
I) for the purposes of idntify other products and services which might be of interest to the Patients
j) for the purposes of informing Patients about the practice's products and services;
k) processing is necessary for pursuing the legitimate interest of the practice or the third party to whom the information is supplied

Withholding consent: I understand that it is the policy of the practice to require all patients to complete and sign the consent. If I exercise my right to withhold my consent to the practice collecting and processing Personal Information, I understand and agree that in this case, the practice reserves the right not to provide dental services (except emergencies) and for which I take full responsibility and indemnify the Practice.

Withdrawal: I understand that I can withdraw this consent at any time and I undertake to inform the practice of my with drawal. In this case, I understand that this may affect my rights and contractual relationship that I have with the practice and for which I take full liability and hereby indemnify the practice.

My consent is provided of my own free will without any undue influence from any person whatsoever.
I confirm that I have permission of my dependent(s) to give their consent, where such consent has been provided and I indemnify the practice against this.

The Practice Information Officer details are:

Dr Stéfan Pheiffer
Email: info@drstefan.co.za

Date of agreement *

Day Month Year

Name

First Name Last Name

I confirm that the details I have given above are correct and I consent to receiving dental treatment. I will inform the clinic if any changes in my medical conditions occur.