Wilgers Dental Studio
DR. FRANCOIS MALAN

MAIN MEMBER INFORMATION

ID NUMBER:_____ SURNAME_____
FULL NAMES:_____ INITIALS:_____ TITLE:_____
DATE OF BIRTH:_____ PREFERRED LANGUAGE:_____ GENDER: M / F
CELL NUMBER:_____ HOME NUMBER:_____ FAX:_____
WORK NUMBER:_____ EMAIL ADDRESS:_____
POSTAL ADDRESS:_____ POSTAL CODE:_____
_____
PHYSICAL ADDRESS:_____ POSTAL CODE:_____
_____
MEDICAL SCHEME:_____
PLAN/OPTION:_____ MEMBER NUMBER:_____

PATIENT INFORMATION

ID NUMBER:_____ SURNAME_____
FULL NAMES:_____ INITIALS:_____ TITLE:_____
DATE OF BIRTH:_____ GENDER: M / F
CELL NUMBER:_____ HOME NUMBER:_____ FAX:_____
WORK NUMBER:_____ EMAIL ADDRESS:_____
OCCUPATION:_____ MARITIAL STATUS:_____

MEDICAL HISTORY

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

Allergies, hay fever, sinusitis	☐	Heart Problems	☐	Thyroid Problems	☐
Anemia	☐	Hepatitis?	☐	Tonsillitis	☐
Arthritis, Rheumatism	☐	Type: _____		Tuberculosis	☐
Artificial Heart Valves	☐	Herpes	☐	Tumor or Growth on Head/Neck	☐
Artificial Joints	☐	High Blood Pressure	☐	Ulcer	☐
Asthma	☐	Any Immune Deficiency (incl. HIV/AIDS)	☐	Venereal Disease	☐
Asthma: Required Hospitalization	☐	Jaundice	☐	Weight Loss, Unexplained	☐
Asthma: Used Steroids	☐	Kidney Disease	☐	Do you wear contact lenses?	☐
Bleeding abnormally with operation/surgery	☐	Low Blood Pressure	☐	Do you consume alcoholic beverages?	☐
Blood Disease, Clotting Disorders	☐	Mitral Valve Prolapse	☐	Are you currently under the care of a Physician?	☐
Cancer	☐	Osteopenia	☐		
Chemical Dependency	☐	Osteoporosis	☐	Are you allergic/sensitive to Latex?	☐
Chemotherapy	☐	Pacemaker	☐	Allergic to penicillin, Aspirin or Other Drugs?	☐
Circulatory Problems	☐	Radiation Treatments	☐	*If Yes, please specify:*	
Cortisone Treatments	☐	Respiratory Disease	☐	_____	
Cough, persistent or bloody	☐	Rheumatic Fever	☐	_____	
Diabetes	☐	Scarlet Fever	☐	Are you currently taking any Medications?	☐
Emphysema	☐	Shortness of Breath	☐	*If Yes, please list:*	
Epilepsy	☐	Sinus Trouble	☐	_____	
Fainting	☐	Sickle Cell Anemia	☐	_____	
Glaucoma	☐	Skin Rash	☐	_____	
Headaches	☐	Stroke	☐	_____	
Heart Murmur	☐	Swelling of Feet/Ankles	☐	_____	

I hereby confirm that all the information supplied is true and I am responsible for any false information provided
NAME IN PRINT:_____
DATE:_____ SIGNATURE:_____

Please note that you (or your parent/guardian) remain liable for the account for service rendered by this practice, even if you are insured by a medical air or other other third party. Please ensure that you have read and signed the attached doctor-patient contract.

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day or **24 hours notice** if they cannot keep an appointment. Appointment changes with **less than 1 days notice are subject to a service fee** based on the number of staff members and the amount of time that was reserved for you.