

Family Dental Centre

PATIENT DETAILS:

Surname: _____ Title and Initials: _____

First Name: _____ Identity Number: _____

Date of Birth: _____ Home Tel No: _____

Email Address: _____ Work Tel No: _____

Cell No: _____

Postal Address: _____

Physical Address: _____

PERSON RESPONSIBLE FOR ACCOUNT or MAIN MEMBER:

Surname: _____ Title and Initials: _____

First Name: _____ Identity Number: _____

Date of Birth: _____ Home Tel No: _____

Email Address: _____ Work Tel No: _____

Cell No: _____

Work Address: _____

Postal Address: _____

Physical Address: _____

MEDICAL AID: _____ **MEMBERSHIP No:** _____**PLAN:** _____ **DEPENDANT CODE:** _____**NEXT OF KIN:**

Name and Surname: _____ Relationship: _____

Tel No: _____ Cell No: _____

Home Address: _____

MEDICAL DOCTOR: _____ Tel No: _____**MEDICAL HISTORY:** Indicate where applicable and give details:

☐ Allergy	☐ Asthma	☐ Epilepsy	☐ Cortisone Therapy	☐ HIV/AIDS
☐ Diabetes	☐ Hypertension	☐ Heart Disease	☐ Jaundice	☐ Blood Disease
☐ Knee Replacement	☐ Hip Replacement	☐ Rheumatic fever	If Pregnant, how many weeks? _____	

Other/details: _____

Current Medication: _____

P.T.O

Protection of Personal Information (POPIA) Consent

In terms of the Protection of Personal Information Act, 4 of 2013 ("POPIA"), I hereby consent to Ozmed collecting, storing, and processing my personal information (including medical and health records) for the purpose of providing dental treatment and related administrative functions.

I understand that:

- My personal information will be used only for legitimate practice purposes and may be shared with third parties such as medical aid schemes, laboratories, or referring practitioners where necessary.
- The practice will take all reasonable steps to safeguard my personal information.
- I have the right to request access to, correction of, or deletion of my personal information, in line with POPIA requirements.
- My personal information will not be shared or used for any purpose unrelated to my treatment without my consent, unless required by law.

Patient Acknowledgement:

I acknowledge that I have read and understood the above and consent to the processing of my personal information as outlined.

Name & Surname: _____

Signature: _____

Date: _____