PLEASE COMPLETE THE FOLLOWING FORM AND EMAIL IT TO: reception@sedationspecialists.co.za

PATIENT:				***PERSON RESPONSIBLE FOR ACCOUNT:***	
Name of Patient:			Dentist / Surgeon: Dr……	Name of Person Responsible for Account:	
Date of birth:	Age:		Patient height:_____m	ID of Person Responsible for Account:	
Date of Operation:	F	M	Patient weight: _____kg	Relationship of person responsible for account to patient:	

Allergy to medicine? / injections? / food?	Yes	No
Problems with previous anaesthetics or sedation?	Yes	No
Porphyria? Malignant hyperthermia? Scoline apnea?	Yes	No
Cortisone treatment in the past 12 months?	Yes	No
How far can you walk on the flat without getting tired?	<1km	<2km ≥5km
How many flights of stairs can you climb before the need to rest?	<1	2 ≥3
High Blood Pressure? / Irregular heart rate? or Palpitations?	Yes	No
Asthma? / Bronchitis? / Emphysema? / Do you smoke?	Yes	No
Heart Disease? / Heart Attack or Angina? / Stents? / Bypass?	Yes	No
Diabetes or thyroid problems?	Yes	No
Kidney or bladder disease?	Yes	No
Epileptic convulsions? / Stroke? / Blackout of any sort?	Yes	No
Sleep apnea? / Snoring? / Excessive daytime Sleep?	Yes	No
**(Female only) Possibility of pregnancy? Are you breast feeding?	Yes	No
**Tendency to bleed or bruise easily?	Yes	No

** If you are **Pregnant**, taking **Warfarin** or **Clopidogrel**, call Dr Thom immediately, *cell*: 0820408049

Please give details of questions answered **YES:**

Home Address:

Postal Address:

Telephone numbers: (h) (w/cell)

Email Address:

Medical Aid Plan:	Medical Aid Number:
Dependency code:	Authorization Code:

List **ALL** Medication with dosage, *including* **Herbal** and **Recreational drugs**

List **ALL Operations** you had in the past 10 years**.**

*Anything that you want to discuss with your Anaesthetist and **not** write down: Y N*

Your GP or Physician's name and contact number:

YOUR ACCOUNT: You will receive a separate account from your Anaesthetist. We charge private fees, based on Discovery Anaesthetic rates. This is in line with guidelines of the South African Health Professions Council and recommendations of the Medical Association of South Africa**.** After your procedure, your account will be transmitted electronically to your Medical Aid and you will receive an email to confirm payment. You are ultimately responsible for the settlement of your account should the medical aid neglect to pay. Private Patients will receive an invoice after the procedure at rates as described above and detailed per email.

TERMS AND CONDITIONS OF PAYMENT: I accept full and complete responsibility for actual and potential costs associated with conscious sedation or General Anaesthesia. I accept full responsibility for the costs that have been explained to me. If the account is sent to the medical aid, the person responsible for the account is liable for the full amount, even if the medical aid short pays, for whatever reason. I accept full responsibility for the account if I am not the main member but the person completing this form in case of non-payment from the main member. Failure to settle the account on request will result in the account being handed over for collection. You will be responsible for any extra costs thereafter – for collection fees 20%,25%, 35%, 50% etc. Interest will be charged at 2% per month on accounts of 90 days and older, which you are responsible for. I agree to comply with the terms and conditions of payment. I confirm that the person responsible for paying the account has been informed of the costs, if it is not the same person signing this form.

SIGNATURE OF PATIENT:	DATE:	SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT:

I / We have read the information on this form and understand the content.

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