



# Dr. Jason P. White

B.Ch.D (Pret), M.Dent (MFO Surg) Dent, DipOdont (Oral Surg) Pret  
Pr. No.: 062 000 0344273

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## Medical history

## Patient details

Title Miss/Mrs/Master/Mr/Dr/Prof/Rev

Full Name: \_\_\_\_\_ Preferred name: \_\_\_\_\_ Surname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ ID: \_\_\_\_\_

Male/Female          Single/Married/Divorced/Other          Occupation \_\_\_\_\_

Home language: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Referring Dentist: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

Family doctor: \_\_\_\_\_

Are you currently in pain? Yes / No

Reason for Visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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**PARTICULARS OF PERSON RESPONSIBLE FOR THE ACCOUNT**

Title Miss/Mrs/Master/Mr/Dr/Prof/Rev

Full Name: \_\_\_\_\_ Surname \_\_\_\_\_

ID: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Name of relative/friend not residing at the same address \_\_\_\_\_ Tel \_\_\_\_\_

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#### **X-RAY SERVICES**

Digital panoramic X-Ray may be necessary for the complete diagnosis and treatment of your case. These X-Rays are mandatory for medical-legal and insurance purposes. We will bill your insurance but make no guarantee of payment. If your insurance denies payment of any X-Ray, you are financially responsible. We do not take unnecessary X-Rays. Unclear or old X-Rays (older than six months) are not adequate for surgical purposes.

\_\_\_\_\_ **Initials** By initialling, I acknowledge that I have read and understand the above regarding X-Rays.

#### **APPOINTMENTS**

The doctors spend a great deal of time with each patient. The doctors' and other patients' time is precious. Please be courteous and if you must reschedule your appointment, please do so only with a 24 hour notice. There is a R500 charge for any surgery appointments cancelled without a 24 hour notice.

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Patient Signature (or legally authorized individual) Date Relationship to patient (parent, legal guardian, etc.)