Dr Larry Uria
ORTHODONTIST
BDS MSc (Dent) MDent (Orth) FCD (SA)

DR LARRY URIA SPECIALIST ORTHODONTIST
PATIENT REGISTRATION, UPDATE AND INFORMATION DETAILS

Patient Details A/C Number.....

Surname…….....First Name.……Initials……..Title……...
Date of Birth……/…../…..Age……...yrs……...months Gender : m □ f □ (tick)
Address ……..……..
……Code……....
Telephone :
home : ……
mob : ……
e-mail : ……
School……...Year……
Occupation……....
Reason for seeking treatment……....
……...
Referral Source (tick) :
□ Dentist □ Family/Friend
□ Advert □ Self
□ Other…….
Name of family/referring dentist……..

Personal Payment Details (Responsible Party)

Surname…….....First Name.……Initials……..Title……..
Relationship to patient……
Employer…….....Occupation…….
Residential Address……...
……Code…….....
Postal Address……...
……Code…….
Telephone :
home : ……
work : ……
mob : ……
fax : ……
e-mail : …….....
Health Fund : ……Number…….
Father's Name :…… Mother's Name :……..

Additional Contact (Relation/Friend)

Surname…….....First Name.……Initials……..Title……..
Relationship to patient……
Telephone :
home : ……
work : ……
mob : ……
e-mail : …….....

PTO…..Fin

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Financial Policy

The patient or parents are responsible for the payment of the account. We do not forward statements to the health fund. Accounts are payable when rendered. Our credit limit is 30 days. Should an account become outstanding for more that 90 days, interest will be charged. Treatment will continue on a CASH PER VISIT basis. Any amount outstanding at the completion of active treatment must be paid in full before the braces can be removed.

Please feel free to discuss any of your concerns with us at any time.

This is to certify that I the undersigned consent to the performing of orthodontic procedures agreed to be necessary or advisable, and I will assume responsibility for the fees associated with these procedures and agree to notify of any change details. I hereby agree to the fee arrangement and consent to treatment.

Signature : _____

Date : _____