VOLTOOI ASB AFDELINGS A, B, C & D
PLEASE COMPLETE SECTIONS A, B, C & D

A. BESONDERHEDE VAN PASIËNT / PARTICULARS OF PATIENT

Van / Surname: .....
Geboortedatum / Date of Birth: .....

Voorname / Names: .....
Noemnaam / Name by which you are called: : .....

Huistaal / Home Language: .....
Naam van Skool/Beroep / Name of School/ Occupation: .....

Tandarts / Dentist: .....
Mediese Dr / Medical Dr: .....

Woonadres / Residential Address: .....
Huis Telefoon nommer / Home Tel. number: .....

Sportaktiwiteite / Sport activities: .....
Stokperdjies / Hobbies: .....

Verwys deur: ☐ Vriende / Friends ☐ Familie / Relatives ☐ Tandarts / Dentist ☐ Self
Referred by:

Kontakpersoon se telefoonnommer: .....
Geslag / Gender: ☐ Manlik / Male ☐ Vroulik / Female

B. NAAM EN ADRES VAN REKENINGPLIGTIGE
NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCOUNT

Van / Surname: .....
Voorletters / Initials: .....

I.D. No: .....
Titel: Prof/Dr/Mnr/Mev/Mej / Title: Prof/Dr/Mr/Mrs/Miss .....

Beroep / Occupation: .....
Werkgewer / Employer: .....

Woonadres / Residential Address: .....
Posadres / Postal Address: .....

.....
.....

Sel/Cell No: .....
Poskode/Postal Code: .....

Tel No (H): .....
Tel No (W): .....

E-pos adres: .....

Mediese Fonds Naam / Medical Aid Name: .....
Mediese Fonds Nommer / Medical Aid No: .....

Mediese Fonds/Medical Aid Plan: .....
Pasiënt Afhanklike Kode: .....

☐ Getroud/Married ☐ Geskei/Divorced ☐ Enkel/Single ☐ Weduwee/Wewenaar/Widowed

C. BESONDERHEDE VAN FAMILIELID OF VRIEND (wat nie by bg adres woon nie)
PARTICULARS OF RELATIVE OR FRIEND (not living at the above address)

Van / Surname: .....
Voorletters / Initials: .....

Woonadres: / Residential Address: .....
Tel No: .....

.....
Verwantskap/Relationship: .....

D. GESONDHEIDSVRAELYS VAN PASIËNT / HEALTH QUESTIONNAIRE OF PATIENT

		JA / YES	NEE / NO
1.	Was daar enige abnormaliteite of beserings tydens geboorte / Were there any abnormalities or injuries at birth	☐	☐
	Spesifiseer / Specify		
2.	Word u tans deur 'n mediese praktisyn behandel / Are you at present being treated by a medical practitioner	☐	☐
	Spesifiseer / Specify		
3.	Is u mangels en/of adenoïde verwyder / Have your tonsils and/or adenoids been removed	☐	☐
4.	Ly u aan / Do you suffer from: Asma / Asthma	☐	☐
	Hooikoors / Hay Fever	☐	☐
	Suikersiekte / Diabetes	☐	☐
	VIGS / AIDS	☐	☐
	Allergië/ Allergies (Spesifiseer/Specify)		
5.	Het u enige van die volgende siektes gehad / Have you had any of the following diseases:		
	Rumatiekkoors / Rheumatic Fever	☐	☐
	Hartkwaal / Heart Disease	☐	☐
	Geelsug / Jaundice (hepatitis)	☐	☐
6.	Het u enige van die volgende gehad / Have you had any of the following:		
	Lip Operasie / Surgery of the Lips	☐	☐
	Ander Gesigsnykunde / Other facial Surgery	☐	☐
	Beserings aan Gesig of Tande / Injuries to Face or Teeth	☐	☐
	Spesifiseer / Specify:		
7.	Was daar of is daar tans 'n duimsuig gewoonte / Was there or is there at present a thumbsucking habit	☐	☐
	Spesifiseer / Specify		
8.	Is enige van u melktande vroeg verwyder / Have any of your milk teeth been extracted at an early age	☐	☐
9.	Het u voorheen ortodontiese behandeling ondergaan / Have you had orthodontic treatment before	☐	☐
10.	Is daar 'n familie geskiedenis van ortodontiese probleme / Is there a family history of orthodontic problems	☐	☐

HANDTEKENING / SIGNATURE .....
DATUM / DATE .....