



### Patient Information Sheet

Your health can influence the dental treatment. We therefore ask you to complete this questionnaire. Your information will be kept strictly confidential and subject to confidentiality.

**particulars:**     female     male    e-mail \_\_\_\_\_

Name \_\_\_\_\_ Private Tel. no. \_\_\_\_\_

Firstname \_\_\_\_\_ Business Tel. no. \_\_\_\_\_

Street & Nr. \_\_\_\_\_ Mobile \_\_\_\_\_

Zip code, Town \_\_\_\_\_ Nationality \_\_\_\_\_

Birth date \_\_\_\_\_ Profession \_\_\_\_\_

Health insurance \_\_\_\_\_ insurance no. \_\_\_\_\_

Do you want to receive an estimate or bill by mail?    Yes  No

Do you receive social welfare?

supplement performance     social care     no support

Legal representatives     female     male

Name, Firstname \_\_\_\_\_ Private Tel. no. \_\_\_\_\_

Street & Nr. \_\_\_\_\_ Business Tel. no. \_\_\_\_\_

Zip code, Town \_\_\_\_\_ Mobile \_\_\_\_\_

Family doctor     Doctor treating     Pediatrician

Name, Firstname \_\_\_\_\_ Private Tel. no. \_\_\_\_\_

Street & Nr. \_\_\_\_\_ Zip code, Town \_\_\_\_\_

### Health Questioner

	Yes	No
- Do you feel currently completely healthy?	<input type="checkbox"/>	<input type="checkbox"/>
- Have you been treated medically lately?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which <b>disease</b> ? _____		
- Have you ever had an operation? If yes, which? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you take any medications regularly? Which ones? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		
_____		
- Do you suffer from cardiovascular diseases? If yes, please check _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Too high too low blood pressure <input type="checkbox"/> Angina pectoris		
<input type="checkbox"/> Heart attack <input type="checkbox"/> Stroke		
<input type="checkbox"/> Heart valve defect, artificial heart valve		
<input type="checkbox"/> Endokarditis		

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CENTRELLA ZAHNÄRZTE

	Yes	No
- Do you suffer from a blood disorder? hemophilia <input type="checkbox"/> anemia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Do you take blood thinning medication? If yes, which kind of? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have an anticoagulation pass?	<input type="checkbox"/>	<input type="checkbox"/>
- Do you suffer from a metabolic diseases? <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Others: _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have allergies? Do you have an allergy passport? <input type="checkbox"/> Hayfever <input type="checkbox"/> Asthma <input type="checkbox"/> Others: _____ Are you hypersensitive to: <input type="checkbox"/> Injection <input type="checkbox"/> Medications <input type="checkbox"/> Mouth rinse <input type="checkbox"/> Food	<input type="checkbox"/>	<input type="checkbox"/>
- Do you take bisphosphonates? (for Osteoporosis?)	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have any joint protheses, pacemaker or other implants? If yes, what kind and since when? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Have you ever had? <input type="checkbox"/> A sinusitis? <input type="checkbox"/> Chemotherapy? Why? _____ <input type="checkbox"/> Rheumatism, Joint swelling? <input type="checkbox"/> Radiotherapy? Where? _____ <input type="checkbox"/> Hormonal disorder? _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Any other serious diseases? If yes, which? _____	<input type="checkbox"/>	<input type="checkbox"/>
- <input type="checkbox"/> Any problems with Lung, Liver, Kidney etc.?		
- Are you pregnant at the moment? Which week? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you or did you have hepatitis? If yes, which? A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Are you tested HIV positiv ( <b>AIDS</b> )?	<input type="checkbox"/>	<input type="checkbox"/>
- Do you smoke or have you ever smoked? How many? _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you consume drugs?	<input type="checkbox"/>	<input type="checkbox"/>

I confirm that I have answered all questions truthfully and completely.

Date \_\_\_\_\_ Signature \_\_\_\_\_