CENTRELLA ZAHNÄRZTE

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?	☐	☐
- Have you been treated medically lately?	☐	☐
If yes, which **disease?** _____		
- Have you ever had an operation? If yes, which? _____	☐	☐
- Do you take any medications regulary? Which ones?_____	☐	☐
_____		
_____		
- Do you suffer from cardiovascular diseases? If yes, please check_____	☐	☐

☐ Too high too low blood pressure ☐ Angina pectoris

☐ Heart attack ☐ Stroke

☐ Heart valve defect, artificial heart valve

☐ Endokarditis

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

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

Date _____ Signature _____