



ZAHNARZT IM GLATT

WELCOME TO OUR DENTAL PRACTICE

Last name _____ First name _____
Date of birth _____ Profession _____
Street, number _____ City, zip code _____
Phone at home _____ Phone at work _____
Mobile phone _____ E-mail _____

For children: mother's name / father's name _____

How did you hear about our dental practice? _____

General medical history

Certain diseases require preventive measures in case of dental treatment. We therefore ask you to answer the following questions completely and correctly. All informations are subject to medical confidentiality.

Are you or were you being treated for:

| | Yes | No | | Yes | No |
|------------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Heart disease/Circulatory problems | <input type="checkbox"/> | <input type="checkbox"/> | Do you have an allergy pass? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack? If so when? | <input type="checkbox"/> | <input type="checkbox"/> | Hypersensitivity to latex, metals etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Chronic respiratory diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease | <input type="checkbox"/> | <input type="checkbox"/> | AIDS, HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| Clotting | <input type="checkbox"/> | <input type="checkbox"/> | Are you suffering from diseases of the immune system? | | |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | If so which? _____ | | |
| Anticoagulant medications | <input type="checkbox"/> | <input type="checkbox"/> | Other diseases: _____ | | |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking medicaments? _____ | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? If so how much? | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastro intestinal disease (ulcus) | <input type="checkbox"/> | <input type="checkbox"/> | Are you or were you addicted to drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? (which month _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Are you happy with your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Cramps | <input type="checkbox"/> | <input type="checkbox"/> | What would you change regarding your teeth? | | |
| Asthma / Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> position of your teeth <input type="checkbox"/> tooth color <input type="checkbox"/> shape of your teeth | | |
| Incompatibility of medications | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Family doctor: _____

We thank you for your disclosures.

With my signature I agree that the conditions necessary for the billing, collection and accounting data to the persons and institutions responsible for this will be forwarded.

Date _____ Signature _____