ZAHNARZT IM GLATT
DANIEL WINTER

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
Heart disease/Circulatory problems	☐	☐
Heart attack? If so when?	☐	☐
Pacemaker	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Blood disease	☐	☐
Clotting	☐	☐
Anemia	☐	☐
Anticoagulant medications	☐	☐
Fainting	☐	☐
Diabetes	☐	☐
Gastro intestinal disease (ulcus)	☐	☐
Thyroid disease	☐	☐
Rheumatism	☐	☐
Epilepsy / Cramps	☐	☐
Asthma / Hay fever	☐	☐
Incompatibility of medications	☐	☐

	Yes	No
Do you have an allergy pass?	☐	☐
Hypersensitivity to latex, metals etc.	☐	☐
Hepatitis	☐	☐
Tubercolosi	☐	☐
Chronic respiratory diseases	☐	☐
AIDS, HIV	☐	☐

Are you suffering from diseases of the immune system?

If so which? _____

Other diseases: _____

Are you currently taking medicaments? _____

Do you smoke? If so how much?	☐	☐
Are you or were you addicted to drugs?	☐	☐
Are you pregnant? (which month _____)	☐	☐
Are you happy with your smile?	☐	☐

What would you change regarding your teeth?

☐ postition of your teeth ☐ tooth color ☐ shape of your teeth

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 _____