



Dear patient, dear parents,

in the interest of an guardian treatment we ask you to give all data completely and truthfully. They are added to your personal record sheet and serve to adapt your treatment to your state of health. All your data are subject to the medical professional secrecy of our entire dental team. Thank you very much!

Name: _____ Date of birth: _____

Address: _____ Tel. no. private: _____

_____ Tel. no. mobile _____

Name of insured person: _____ Date of Birth: _____

Address of insured person (home address): _____ Tel. no. private: _____

_____ Tel. no. mobile _____

Profession / employer: _____ Tel. no.: _____

Family doctor : _____ Tel. no.: _____

Name of health insurance: _____

Aid yes no

Date of your last dental treatment: _____

Is the last dental treatment completed? yes no

How did you hear about our dental office? _____

Why do you come to the dental treatment today? _____

Do you / did you suffer of any of the following diseases?

Cardiovascular disease yes no

High blood pressure yes no

Low blood pressure yes no

Allergies yes no

If yes, please describe: _____

Diabetes yes no

Asthma yes no

Infectious diseases, for example TBC, HIV yes no

Increased bleeding tendency yes no

Liver disease, for example Hepatitis (jaundice) yes no

Other infections / diseases? _____

What kind of medications do you take regularly? _____

To our female patients - are you pregnant? yes no

Do you want an education about special dental treatments?

(alternatives to amalgam, bleaching,...) yes no

Are you interested in individual prophylaxis?

(professional tooth cleaning, intensive fluoridation, specific techniques for individual dental hygiene,...) yes no

I insure to communicate each change of my data before a further treatment. I am informed that injections can impair the reactivity in the traffic. With the treatment of calculations by a dental account company I agree.

Date _____

Signature _____