wünsche
natürlich gesunde zähne

A warm welcome to our practice!

We are always about to offer you the best possible dental treatment. As you know, dentistry is overlapping other medical disciplines. Therefore it is needful to your own security to fill out this form thoroughly and truthfully. Your personal data is carefully kept secret to the public. In case you would need our assistance, please do not hesitate to ask us.

Surname	Name	Titel	Date of birth

In case of divergence: surname, name, date of Birth of main insured person

Address: street name, house number — Postal code, town

Phone-No.: — Mobile phone:

E-mail — Profession

Health-insurance		Yes	No
	beneficiaries of aid	O	O
	PHI basic charge	O	O
	Supplementary insurance	O	O

When was the **last dental appointment**?

When was the **last x-ray of the jaw area**?

When was the **last professional tooth cleaning**?

What is the **reason for the visit**?

How did you found out about us?

Our surgery works with an appointment system. To allow you top quality of dental treatment without feeling rushed and time pressure please cancel your appointment at least **48 hours** advance.

Please complete the backside

Are you under medical treatment? If yes, for what reason?

Please tell us the name and address of your medical practitioner.

Are you taking any medicine currently or regularly? If yes, which?

Are there any known allergies you suffer against materials or medicine?
If yes, against what?

For female patients: Are you pregnant? Please tell us the month.
Are you in breastfeeding?

Are you suffering (Underline as appropriate):
Heart defect/ heart attack, rapid heartbeat, **high/ low Blood pressure**?
Thrombose, **Embolie**? If yes, when was it?
Do You have a **„Herzpass" (heart disease record card)**?

Do you have **increased bleeding tendency** or a **blood flow disorder**?
Do you easy get bruising or nosebleed? Do you have anaemia?

Have you ever had a faint during the dental treatment?
Do you often have headache oder neck pain/ muscle tenseness? Are you suffering from tinnitus or migraine? Do you grind your teeth?

Are you suffering (Underline as appropriate)
A hepatic disease (Hepatitis), kidney disease, enteropathy, Epilepsie, thyroid disease, respiratory disease, tumor disease, leukaemia, HIV, diabetes or other disease?

Do you smoke? How many cigarettes?

Please inform us as soon as something has changed.

We thank you for your active cooperation.

date/ patient signature dentist signature