Zahnarztpraxis

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Welcome to our practice

We are pleased, that you are visiting us.

Personal information:

Name	Surnames
Date of birth	Marital status
Street / No.	Postal code / Residence
AHV Number	Title
Telephone privat	Telephone business
Cell-phone	E-mail
Occupation	Employer
Family doctor	Telephone family doctor
Health insurance	Health insurance number

Name and surname of the child's parent or patronized person's legal guardian

Name	Surname	Title
Street / No.	Postal code / Residence	Zusatz

How did you find out about our practice?

Privacy Policy:
I have read and agree to the practice's privacy policy.
The privacy policy can be accessed with the QR code or viewed in the practice.

Date	Signature

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Health questionnaire:

Many people have diseases. Often a controlled disease is so habitual that you don't think about it. This can have consequences for your dental treatment. Therefore we kindly ask you to complete the following questionnaire (it's your case history and strictly confidential). The information disclosed herein is subject to professional discretion.

What is the main reason for your consultation?

_____

- **Have you been to the hospital or had medical treatment within the last two years?** Yes* No*
  If Yes, why?
  _____
- **Are you taking pharmaceuticals regularly?** Yes No
  If Yes, what kind?
  _____
- **Allergies**: Yes No
  Have you ever had an adverse reaction to any injections, pharmaceuticals or food (i. e. penicillin, iodine, sulfonamide, etc.)
  If Yes, what kind?
  _____

  Do you suffer from allergic asthma (hay fever)? Yes No
- **Bluterkrankungen**:
  Do you take any blood thinners (value of quick/INR)? Yes No
  Did you ever have any problems from prolonged bleeding? Yes No
  Do you suffer from anaemia? Yes No
- **Heart diseases**:
  Do you suffer from any heart problems? Yes No
  Do you suffer from:
  high blood pressure? Yes No
  or **low** blood pressure? Yes No
  Do you have a **pacemaker**? Yes No
- **Do you suffer from any respiratory diseases**? Yes No
- Do you suffer from any **gastrointestinal disorder (gastric ulcer)**? Yes No
- Do you suffer from any **kidney disease**? Yes No
- **Metabolism diseases**:
  Diabetes Yes No
  Thyroid gland disorder Yes No
  any other metabolic disease _____ Yes No
- **Neurological disease** _____ Yes No
- **Do you have a glaucoma**? Yes No
- Do you need an **endocarditis prophylaxis**? Yes No
- Do you have a **valvular prothesis**? Yes No
- Do you have an **articula prothesis** (knee, hip, etc.)? Yes No
- **Do you suffer from a chronic infection (Hepatitis B/C/HIV)**? Yes No
- **Have you ever had**:
  A sinusitis of the maxilla? Yes No
  Rheumatism, polyarthritis rheumatica? Yes No
- **Any other serious disease?** Yes No
  If Yes, what kind? _____
- **Do you smoke?** Yes No
- **Are you pregnant?** Yes No

Date: _____ Signature: _____

* Please mark what is applicable