Welcome to our dental practice!

Dear patient,

we are pleased to welcome you in our dental practice.

In order for your treatment to be customized according to your wishes, we need some information about your general health in addition to your personal details.

This is important for an adequate and risk-free treatment.

All information is of course subject to medical confidentiality.

Personal Surname / First name:	
Gender: male () female () diverse ()	
Date of birth:	
Street / No.	
Postal code / City:	
Private telephone number:	Mobile tel. number:
E-Mail:	Fax:
*Job, Company name:	Work tel. number:
Name and address of the attending general practitioner: Insurance	
Health insurance / private health insurance:	
() Public insurance O Additional insurance	() Private insuranceO Basic rate
Additional insurance	Subsidy tariff
In the case of family insurance, different information of	the insured/payee:
Surname / First:	
Gender: male () female () diverse ()	
Birth Date:	
Street / No.:	
Postal Code / City:	
Would you like to be included in our RECALL pro-	gram? () Yes () No
How did you hear about our practice? Google () Homepage () Practice sign Were you recommended to us? Yes () *If yes, by whor	() n?

Cardiovascular diseases Increased blood pressure (Hypertension) Niedriger Blutdruck (Hypotension) Tachycardic arrhythmia Angina pectoris Heart valve disease Cardiac pacemaker Stent Are you on endocarditis prophylaxis?	() Yes () No () Yes () No	Medication:
Infectious diseases Hepatitis A, B, C HIV positive Tuberculosis Covid-19 Other infectious diseases?	() Yes () No () Yes () No () Yes () No () Yes () No () Yes () No	Medication:
Allergies / Intolerances Local anesthetics Sulfitallergy Painkiller Antibiotics Other Allergies / Intolerances?	() Yes () No () Yes () No () Yes () No () Yes () No () Yes () No	Medication:
Other diseases Blood coagulation disorders Asthma Lung disease Liver disease Thyroid disease () Hyper-/() Subfunction Rheumatism Epilepsy Diabetes Gastrointestinal disease Renal dysfunction Fainting tendency Cataract Glaucoma Current/previous tumor disease? Which one?/ When? Current or previous radiation/chemotherapy? Osteoporosis Do you take bisphosphonates?	() Yes () No	Medication:
If so, please ask for our separate bisphosphonate medical history form. Other diseases?	() Yes () No	

Do you smoke?	() Yes () No
How many per day?/ Since w	when?
Are you pregnant?	() Yes () No
We kindly ask that you keep scheduled your	appointments or cancel them at least 24 hours in advance.
This gives us the chance to offer appointment be charged.	nts to other patients. Otherwise, any resulting costs may
*optional details	
Date	Patient's signature