Praxis für Parodontologie und Implantologie
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Welcome to our Office !

Before we will talk about your oral health problem we need some general information and some information about your medical health history.

Patient Information
Mr/Mrs

Last Name | First Name | Date of birth

Place of birth

Insured Person

Last Name | First Name | Date of Birth

Home Address

Street Name | No | Home Phone

Zip Code | City | E-Mail Adresse

Health Insurance

Name of Group Dental Plan | Name of Insurance Co

Occupation

Patient's Occupation

Employer

Name | Address | Work Phone

To avoid misunderstandings regarding dental insurance, we wish that our patients know that ALL PROFESSIONAL SERVICES RENDERED are CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We do not render our services on the basis that insurance companies will pay our fees.

Medical Treatment : Are you currently under medical treatment? □ yes □ no
If so, for which disease?

_____

_____

Drugs/Medications : Do you take any medication on a regular basis? If so, please list the name of the medication and for which disease you are taking it?

_____

_____

_____

Bisphosphonate : Are you/have you been under bisphosphonate therapy? □ yes □ no
If so, intravenous □ or oral □

Endoprosthetics	:	Do You have a hip or knee replacement prosthesis or other titanium plates/screws inserted	□ yes □ no
Antibiotic prophylaxis	:	Do you need endocarditis prophylaxis or antibiotic prophylaxis for another reason?	□ yes □ no
Allergies	:	Are you allergic to drugs (ie antibiotics or local anesthetics) or other substances If yes, please list them below? _____	□ yes □ no
Do you have:		An allergy pass?	□ yes □ no
Heart Diseases	:	Cardiac insufficiency ?	□ yes □ no
		Arrhythmia ?	□ yes □ no
		Angina pectoris ?	□ yes □ no
		A pacemaker or a cardiac valve replacement graft ?	□ yes □ no
Circulatory disturbances	:	High blood pressure ?	□ yes □ no
		Low blood pressure ?	□ yes □ no
		Did you ever have a heart attack?	□ yes □ no
		Or a stroke ?	□ yes □ no
		Do you take anticoagulant medications?	□ yes □ no
Metabolic diseases	:	Diabetes ? _____	□ yes □ no
		Gastro-intestinal diseases? _____	□ yes □ no
		Disease of the thyroid?_____	□ yes □ no
		Osteoporosis?_____	□ yes □ no
Diseases of the Nervous System	:	Epilepsy ?	□ yes □ no
		Spasms ?	□ yes □ no
Bleeding disorders	:	Problems with wound healing?	□ yes □ no
		Increased bleeding tendency after injuries or hemophilia ?	□ yes □ no
		Anemia ?	□ yes □ no
Infectious diseases	:	Hepatitis A/B/C _____) ?	□ yes □ no
		Tuberkulosis ?	□ yes □ no
		Chronic diseases of the respiratory tract, cough or asthma ?	□ yes □ no
		Did you ever have an HIV Test ? If so, what was the result ? _____	□ yes □ no
Further Information	:	Other diseases ? _____	□ yes □ no
		Do you drink alcoholic beverages ? If so, how much? little □ medium □ above average □	□ yes □ no
		Do you take drugs or amphetamines ?	□ yes □ no
		Do you get canker sores?	□ yes □ no
		Do you wish consultation about the treatment of bad breath?	□ yes □ no
X-Rays	:	Did you have x-rays taken of your teeth or face within the last 12 months ? If you wish that we have those x-rays send to our office, please give us the name of the dentist where to ask for them _____ **We do use a digital x-ray system in our office to minimize the x-ray exposure for our patients!**	□ yes □ no
For females only	:	Are you pregnant? If so, how many months? _____	□ yes □ no

Thank you for your cooperation!
If there are any changes to the above listed informations, please let us know immediately.

Date:_____ **Signature:**_____