Welcome to our practice, your new dental comfort zone.

Please read thoroughly and fill out this entire form

Surname	Name
Date of Birth	☐ Female ☐ Male
Address	PO Box/ City
Tel.	Fax
Mobile	@
Profession	Doctor
	Visiting for:

Medical history

All information below is subject to medical confidentiality. Please choose for every question the suitable answer.

Yes	No	
☐	☐	Did you suffer of any disease lately or were you treated / hospitalized?
☐	☐	Do you need or take any medication on a regular basis? If so, what kind?
☐	☐	Did you ever had a severe disease or surgery? If so, what kind?
☐	☐	Did you ever suffered of an allergic reaction to medication, anaesthesia or food?
☐	☐	If hurt, do you bleed for a long period?
☐	☐	Do you think that you suffer of bad breath?
		Do you or did you suffer in the past of any of the below mentioned diseases?
☐	☐	Allergies? Do you possess an allergy pass?
☐	☐	Any cardial / cardiovascular diseases or defects?
☐	☐	Heart pacemaker?
☐	☐	Diabetes?
☐	☐	Liver oder kindey diseases?
☐	☐	Gastro-intestinal diseases?
☐	☐	Respiratory or lunge diseases?
☐	☐	Epilepsy?
☐	☐	Rheumatic diseases?
☐	☐	Infectious diseases? (especially Tuberculosis, HIV, Hepatitis)
☐	☐	Do you suffer of any other disease not listed? If so, what kind?
☐	☐	For women: Are you pregnant?

Declaration

I authorize my dentist to access any personal medical files relevant to treatment. Further, I consent for my dentist to use or give out data related to financial services to specialized persons or institutions. My dentist is also allowed to use any pictures or radiographs for publications or seminars.

Date	Signature