Health History Form

Certain health conditions can influence your dental procedure.
Therefore, please answer the following questions carefully!
Your information will, of course, be treated confidentially.

Last Name: ..... First Name: ..... Birthdate: .....

Current Mailing Address Zip Code: _ _ _ _ _ City: .....

Street: No.: .....HomePhone.....

Email-Address: ..... Cell Phone: .....

Occuption: .....

Name of health insurance:.....

Do you have an additional insurance?.....

Are you excempt from co-payments?.....Yes O / No O

Do you take medication regularly? If so, which ones? .....

Do you have any systemic diseases? If so, which ones?..... Yes O / No O

What medications do you not tolerate? .....

Are you pregnant? If yes, week of pregnancy: ..... maybe O / Yes O / No O

Are you nursing? ..... Yes O / No O

Are you prone to faint or have low blood pressure? ..... Yes O / No O

Do you have high blood pressure? ..... Yes O / No O

Have you ever had an infectious diseases such as hepatitis, tuberculosis or others?..... Yes O / No O

If so, which ones?.....

Do you have diabetes? .....Yes O / No O

Do you have HIV? .....Yes O / No O

Do you have rheumatoid arthritis? .....Yes O / No O

Do you suffer from cancer? Or have you had cancer in the past?.....Yes O / No O

If so, what kind of cancer?
.....

Do you smoke? If so, how many cigarettes per day?.....Yes O / No O

Do you drink alcohol regularly?.....once a week O / 2-3x week O / daily O / None O

Do you take recreational drugs? ..... occasionally O / frequently O / No O

Have you noticed clicking, popping or discomfort in the jaw? .....Yes O / No O

Do you have any pain in your jaw joints? .....Yes O / No O

Do you brux or grind your teeth? .....Yes O / No O

Please continue on the back page →

Do you have earaches or neck pains? ..... Yes O / No O

Do you have backpain? ..... Yes O / No O

Do you often have headaches? If so when?: ..... Yes O / No O

We recommend check-ups every six months, which are covered by your health insurance.

Would you like us to remind you of your dental check-ups?

by text message O / by postcard O No reminder O

Would you like to be reminded of your dental cleaning appointment? .....Yes O / No O

Would you like to be reminded of your appointment by text message? .....Yes O / No O

Are you interested in an overall comprehensive treatment plan?.....Yes O / No O

Are you familiar with our professional dental cleaning program

to prevent caries and periodontitis?.....Yes O / No O

How did you hear about our practice?

By coincidence O facebook O Internet O other O referred by .....

Are family members patients of this practice? .....Yes O / No O

Do you have personal wishes or recommendations for treatment for our practice?.....

Date: ..... Signatur: .....