Many illnesses can influence your dental procedure.
Therefore, please asnwe the following questions carefully!
Your informations will, of course, be treated confidentially.

Wich medications do you take regularly? .....

Do you have any systemic diseases? yes ○ / no ○ Which? .....

Are there any medications you do not tolerate? .....

Do you tend to fainting or poor circulation? yes ○ / no ○

Do you have high blood pressure? yes ○ / no ○

Do you have any allergies? yes ○ / no ○ Which? .....

Have you ever had infections like Hepatitis B, Tuberculosis or others? yes ○ / no ○ Wich?.....

Are you pregnant? yes ○ / no ○

Do you have Diabetes? yes ○ / no ○ Rheumatitis? yes ○ / no ○

HIV? yes ○ / no ○

How many cigarettes do you smoke on a daily basis? : non / <10 / > 10

If you are not a smoker, where in the past? Until when: How many: <10 / > 10

Do you drink alcohol? no/ about once a week / 2-3 times a week / daily

Do you take other drugs? no/ sometimes/ often

Have you ever noticed any popping or clicking of your jaw? yes ○ / no ○

Do you have any pain in your jaw? yes ○ / no ○

Do you grind your teeth? yes ○ / no ○

Do you have any shoulder or neck tension? yes ○ / no ○

Do you have back pain? yes ○ / no ○

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

Current Mailing Addres Zip Code: | | | | | | City: .....

Street, No.. ..... Home Phone: .....

e.mail-address: ..... Work Phone: .....

Occupation: ..... Cell Phone: .....

Workplace : ..... Cell Phone Provider (D2, E-Plus): .....

How did you hear about our office?

O by accident O close to home O facebook

O referred by.....

Are you children or family members patients of ours as well? yes O / no O

Comments for our office / Wishes about your treatment:

.....

Have you heard of our Prophylaxe-Program to prevent cavities and periodontitis? O yes / O no

We recommend dental check-ups every six months.

Would you like to be reminded of your next check-up

every six months or yes O / no O via text message O / mail O

once a year? yes O / no O via text message O / mail O

Are you interested in an overall concept for your teeth? yes O / no O

Or (and) would you like to have treated a particular problem? yes O / no O

Date:..... Signature:.....