

Patient Data Sheet

Family Name, First Name (Patient)

Date of Birth, Sex: m f

Street Address

Zip, City, Country

Home Phone/Cell Phone

Work Phone

E-Mail

Profession

Insurance Company Name

Referring Physician - Name, Address, Phone

Family Doctor - Name, Address, Phone

If insured person is differing from patient mentioned above please fill in:

Family Name, First Name (insured person)

Date of Birth

Street Address

Zip, City, Country

Consent of Treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date

Parent/Legal Guardian Signature

**Please answer the following questions regarding your state of health
as exactly as possible:**

State of Health

Please mark

Further Information

Cardiovascular Diseases:

Hypertension

Yes No

Hypotension

Yes No

Valvular Heart Disease/Defect

Yes No

Endocarditis

Yes No

Heart Surgery

Yes No

Pacemaker

Yes No

Infectious Diseases:

AIDS

Yes No

Hepatitis

Yes No

Tuberculosis

Yes No

other:

Allergies / Intolerances:

Local Anesthetics Yes No

Analgesics Yes No

Antibiotics Yes No

other:

Further Diseases:

Coagulation Diseases Yes No

Asthma Yes No

Lung Diseases Yes No

Thyroid Diseases Yes No

Rheumatism Yes No

Epilepsy Yes No

Diabetes Yes No

Nephropathy Yes No

Fainting Yes No

other:

General Data:

Drug Addiction Yes No

Drinking of alcoholic beverages Yes No If yes, seldom often regularly

Smoker Yes No If yes, 0-10 over 10 cigarettes/day

Regular Medication/Drugs Yes No If yes, since when / Name:

X-Rays taken before Yes No If yes, Date / Body Parts:

Gravidity/Pregnancy Yes No If yes, what month:

How did you get informed about our dentist's practice?

Important Information:

- All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electronically.
- I engage myself to inform you immediately about all changes occurring during the period of treatment.
- I engage myself to keep agreed appointments or to cancel them at least 2 days in advance, otherwise occurring costs can be invoiced.
- I certify with my signature that I have read and understand all above printed **information**.

Date

Patient Signature and Parent/Legal Guardian Signature