Patient questionnaire:

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Dear patient,

please complete this questionnaire in order to ensure best possible dental treatment and care. Please keep us informed of any changes in your medication.

Last name, first name: _____date of birth: _____

Street, number: _____

Postal code, city: _____

Telephone number: _____

Mobile number: _____email:_____

Job: _____

Insurance: _____

Dear patient of statutory insurance, please notice that if we don´t have your health insurance card before the end of actual quarterly period, you will get a bill.

If you can´t come to your appointment, please inform us 24 hours before.

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Cardiovascular disease? Yes ☐ No ☐

(specifally: hypertension, valvular heart defect, arrhythmia, former heart attack, cardinal stent)

if so, which? _____

Other affections Yes ☐ No ☐

☐ Chronic obstructive lung disease
☐ Gastro-intestinal disease
☐ Liver disease
☐ Infectious diseases? (hepatitis, HIV)

Hemopathy or hemorrhage? Yes ☐ No ☐

Do you take coagulation inhibitors for example:
☐ ASS
☐ Xarelto
☐ Plavix Other _____

Diabetes mellitus Yes ☐ No ☐

Insulin required? Yes ☐ No ☐

latest HbA1c- result _____ date:_____

Allergies/hypersensivity reactions?

_____

_____

Do you take any medication? If so, which?

_____

_____

Do you have any radiotherapeutic treatment in head or throat area? Yes ☐ No ☐

year _____

Had you further operations in order with your tooth or jawbone? Yes ☐ No ☐

year _____

Are you pregnant? Yes ☐ No ☐

week _____

Your family doctor (name, city)

_____

Your dentist (name, city)

_____

since _____

Are you a smoker? Yes ☐ No ☐

ca. _____ cigarettes / day, since _____ years

Do you want to quit smoking?
1----------5----------10
No maybe yes

Questions for patients which need a periodontal or implant therapy

Do you have gum bleeding?

Yes ☐ No ☐

Do you have loose teeth?

Yes ☐ No ☐

Do you have a further periodontal scaling?

Yes ☐, year _____ No ☐

Do you have a professional dental cleaning regularly?

Yes ☐, _____ per year No ☐

_____ _____

Place, date Signature