

Welcome to our clinic!

Dear patient,
first we need your personal details and some information about your common health situation. This is important for a treatment with the lowest possible risk. After that we will talk about your wishes. All the statements are subject to the legal requirement concerning confidential medical communication between patient and physician.

Surname: _____ **First-name:** _____ **Date of birth:** _____

Street + No.: _____ **Tel. No.:** _____

Postcode: _____ **City:** _____

E-mail adress: _____

Health insurance: _____

Occupation: _____ **Employer:** _____

Referring dentist / physician: _____

Other recommendation?: _____

Do you have a private additional insurance? Yes No

For private patients: Do you have an additional insurance for the compulsory health insurance fund? Yes No

Do you have a private basic rate? Yes No

Are you currently in medical treatment?

What kind of diseases? : _____

Physician / specialist: _____

Do you take any drugs regularly? Yes No

What kind of drugs? _____

Do you take any anticoagulant drugs? Yes No

For example ASS / Marcumar: _____

Please turn over!

Do you have heart diseases?

Yes No

What kind of heart diseases? _____

Do you have blood circulation diseases?

High blood pressure? Yes No Low blood pressure? Yes No

Are you aware of any allergies?

Yes No

What kind of allergies? _____

Do you take **bisphosphonate** medications?

Yes No

What kind of bisphosphonate medications? _____

Do you have epileptic seizures/ fits?

Yes No

Do you have increased bleeding tendency
(haemophilia/ blood diseases)?

Yes No

Do you have diabetes mellitus?

Yes No

Do you have thyroid diseases?

Yes No

Do you have Hepatitis A/B/C or icterus (jaundice)?

Yes No

HIV +

Yes No

Others: _____

Were X-rays taken of the head, jaw or dental area in the past few years?

In which surgery? _____

Are you pregnant?

Yes No

In which month? _____

I agree to medically necessary performed services, which will not be recompensed by the compulsory health insurance fund? Yes, after consultation No

Date: _____ Signature: _____

For private patients:

I am a private patient and will pay the costs of treatment by myself.

Date: _____ Signature: _____