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
(haemophillia/ 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: _____