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 immediatelly about all changes occuring during the period of treatment.
- I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occuring 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