

Patient Last Name, First Name, Address

Patient Questionnaire

Date of Birth:

Email:

Phone (home):

(Work):

Occupation:

Primary Physician: Name:

Address: Phone:

Please answer the following questions about your state of health as accurately as possible. This information is subject to medical privacy and data protection laws and will be handled with strict confidentiality.

Heart/cardiovascular diseases:

- High blood pressure Yes No
- Low blood pressure Yes No
- Heart valve disease Yes No
- Heart valve replacement Yes No
- Pacemaker Yes No
- Endocarditis Yes No
- Heart surgery Yes No

- Severe neutropenia Yes No
- Cystic fibrosis Yes No
- Organ transplant Yes No
- Stem cell transplant Yes No

Epilepsy

Yes No

Asthma/lung diseases

Yes No

Blood clotting disorders

Yes No

Diabetes

Yes No

Drug dependency

Yes No

Nerve disease

Yes No

Kidney diseases

Yes No

Fainting spells

Yes No

Osteoporosis

Yes No

Smoker

Yes No

Rheumatism/arthritis

Yes No

Thyroid disease

Yes No

Other diseases:

Yes No

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Infectious diseases:

- HIV/AIDS Yes No
- Liver disease/Hepatitis Yes No
- Tuberculosis Yes No
- Other infectious diseases Yes No
- Creutzfeldt-Jakob disease (CJD)/New variant Creutzfeldt-Jakob disease (vCJD) Yes No

Allergies or intolerances:

- Local anesthesia/injections Yes No
- Antibiotics Yes No
- Pain medication Yes No
- Metals:
- Yes No

Are you pregnant? Yes No
If yes, what month?month

Have you had dental x-rays?
If yes, when?

Which medication do you take regularly or are currently taking? since

- Do you take bisphosphonates? Yes No since
- Are you receiving chemotherapy medication? Yes No since
- Are you receiving radiation therapy for cancer? Yes No since
- Are you taking high-dosage steroids / immunosuppressants? Yes No since
- Have you had major surgery carried out in hospital? Yes No Date:.....

I hereby authorise the electronic storage, processing and use of my data for input in the Recall System.

I agree to immediately report any and all changes arising during the entire treatment period. I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

In the case of extensive services by dentists or dental technicians for which my dentist is obliged to make payment in advance, I understand that a credit check may be carried out by a credit protection or credit reporting agency.

Location: Date:

Signature: