Patient Last Name, First Name, Address

Patient Questionnaire

Date of Birth:

Email:

Phone (home): ..... (Work): .....

Occupation/Employer: ..... 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

Allergies or intolerances:		
Local anesthesia/injections	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No
Pain medication	☐ Yes	☐ No
Metals:		

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 .....

..... 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 .....

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: .....