Patient: Nr.:

Name:

Date of birth:

telephone number(s):

e-mail:

job:

Have you had an X-ray in the last 1/2 year

Yes ( ) No ( )

Do you agree with taking X-ray photographs if we need it for your treatment?

Yes ( ) No ( )

Name of family doctor:

Name of dentist:

Are you receiving medical treatment at time?

Yes( ) No ( )

for what?

Do you suffer from (please tick!):

( ) heart-/circulation diseases
( ) too low/high blood pressure
( ) liver/hepar diseases
( ) blood diseases/bleeding tendency
( ) stroke
( ) diabetes/sugar disease
( ) kidney diseases
( ) gastric-/intestinal diseases
( ) asthmatic
( ) rheumatism
( ) epilepsy
( ) multi resistent bacteria
( ) glaucoma
( ) thyroid diseases
( ) **Infectious diseases:(which?)**
  ( ) hepatitis
  ( ) HIV / Aids
  ( ) TBC (tuberculosis)
( ) other diseases:

are you **allergic**?

yes ( ) No ( )

to what?

medicine intolerance?

Yes ( ) No ( )

to what?

blood coagulation disorder/**bleeding tendency**?

Yes ( ) No ( )

Do you have a cardiac pacemaker?

Yes ( ) No ( )

Do you take medicine/drugs ?

Yes ( ) No ( )

Which ones?

blood thinner? Y( ) N( )

bisphosphonates? Y( ) N ( )

Are you **pregnant**?

Yes ( ) No ( )

I agree with taking nessecary radiographs before, while and after treatment: Yes( ) No( ).

I will hereby notified that my airworthiness in road traffic among influential from injections (anaesthetic) and medicine can be affected for 4-6 hours after application.

to my agreed dates for treatment i turn up on time or cancel 24 hours before.

I understood all questions and answered them with my best knowledge.

I guarantee for the correctness of my answeres.

date signature Patient/ legal representatives:

kiefer chirurgie gera