**Particulars**

First name: Surname:

Date of bith: Marital status:

Under age persons

Guardian:

Adress: post code/residence:

Phone: Tel. business

Mobile phone: E-Mail:

occupation: employer:

Referring physician: Dr. City

Family doctor: Dr. City

sponsorr: ❑ health insurance:…………………...…………..............................

 ❑ private patient:……………………………………………………...

 ❑ IV, canton:…………………………………………………………..

 ❑ accident insurance:…………………............................................

 Accident date:………………………………………………............

Versicherungsstatus:

(in-patient stay)

* + - * + general
				+ semiprivate
				+ private

**Health history – Please tick the appropriate box yes No**

1. Were you in hospital oder ambulant in a (dental) treatment? ❑ ❑

If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you take require medication?

 ❑ ❑

If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you take blood thinner or are you prone to increased bleeding? ❑ ❑

4. Do you suffer from heart disease? ❑ ❑

5. Is your blood pressure increased? ❑ ❑

6. Do you ever had an unusual reaction? (allergy, impotence,..)

injections, medication, or dental materials? ❑ ❑

If yes, which substance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Did you ever had following diseases?

 - asthma ❑ ❑

 - hay fever ❑ ❑

 - diabetes ❑ ❑

 - epilepsy ❑ ❑

 - frequent headaches ❑ ❑

 - stomach- or intestinal ulcers ❑ ❑

 - rheumatism ❑ ❑

8. Do you have infectious diseases (hepatitis, HIV, AIDS, tuberculosis..) ❑ ❑

9.Do you smoke? ❑ ❑

10. Do you have or had any other seriosly diseases?

If Yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ ❑

11. women: Are you pregnant? ❑ ❑

Date: …………………………. Signature:……………………………...…