GESICHT KIEFER SCHWEIZ GRUPPE
SWISS MAXILLOFACIAL ASSOCIATES

ZENTRUM WINTERTHUR

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:……………………………..…