Patient Data Sheet

Patient

Family Name, First Name (Patient) _____

Date of Birth _____ Sex: m ○ f ○

Place of Birth _____

Street Address _____

Zip, City, Country _____

Home Phone/ Cell Phone _____ Work Phone _____

E-Mail _____

Profession _____

_____

Insurance Company Name

If the insured person is differing from patient mentioned above please fill in:

Family Name, First Name (Patient) _____

Date of Birth _____

Street Address _____

Zip, City, Country _____

Family Doctor

Name _____

Address _____

Phone _____

Consent of Treatment of a Minor

If the patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date _____

Parent / Legal Guardian Signature _____

see overleaf for further information

Dental Center Gangelt

Please answer the following questions regarding your state of health as exactly as possible:

State of Health	Please mark
Cardiovascular Diseases:	
Hypertension	yes ◯ no ◯
Hypotension	yes ◯ no ◯
Valvular Hearth Disease/Defekt	yes ◯ no ◯
Endocarditis	yes ◯ no ◯
Heart Surgery	yes ◯ no ◯
Pacemaker	yes ◯ no ◯
Infestious Diseases:	
AIDS	yes ◯ no ◯
Hepatitis	yes ◯ no ◯
Tuberculosis	yes ◯ no ◯
other:	

Further Diseases:

Coagulation Diseases	yes ◯ no ◯
Asthma	yes ◯ no ◯
Lung Diseases	yes ◯ no ◯
Thyroid Diseases	yes ◯ no ◯
Rheumatism	yes ◯ no ◯
Epilepsie	yes ◯ no ◯
Diabetes	yes ◯ no ◯
Nephropathy	yes ◯ no ◯
Fainting	yes ◯ no ◯
other:	

State of Health	Please mark
Allergies / Intolerances:	
Local Anesthetics	yes ◯ no ◯
Analgesics	yes ◯ no ◯
Antibiotics	yes ◯ no ◯
other:	

General Data:

Drug Addiction	yes ◯ no ◯
Drinking of alcoholic beverages	yes ◯ no ◯
If yes, ◯ seldom ◯ often ◯ regularly	
Smoker	yes ◯ no ◯
If yes, ◯ 0-1 ◯ over 10 cigarettes / day	
Regular Medication / Drugs	yes ◯ no ◯
If yes, since when / Name:	
X-Rays taken before	yes ◯ no ◯
If yes, Date / Body Parts:	
Gravidity / Pregnancy	yes ◯ no ◯
If yes, what month:	

Important Information:

- All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electonically.
- I engage myself to inform you immediatelly about all changes occuring during the period of treatment.
- I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occuring costs can be invoiced.
- I certify with my signature that I have read and understand all above printed information.

Date

Patient Signature and Parent / Legal Guardian Signature