WYMANN
ZAHNARZT

reset form

☐ Female ☐ Male Title: Civil status: ☐ single ☐ married ☐ divorced ☐ widowed

Family name: First name: Date of birth:

Street: ZIP, City:

E-mail: Tel. P:

Profession: Employer: Tel. B:

Parents / legal representatives: Tel. C:

Health insurance (adress):

Physician, treating doctor (adress, tel.):

Dentist; former dentist:

	Yes	No
Do you have support from a care provider, social service, social insurance or missionary?	☐	☐
Would you like a SMS reminder for your appointments?	☐	☐

How did you find out about our dental practice?

I hereby agree that the medical file of my former dentist may be seen and relevant data for invoicing, debt collection and accounting may be forwarded to persons and institutions authorized by you.

All your information is subject to medical confidentiality

Please check the appropriate box	Yes	No
Are you presently being treated by a doctor?	☐	☐
Have you been hospitalized recently?	☐	☐
Do you routinely take medicine?	☐	☐
When yes, list.		
Have you had unusual reactions to injections or medicines?	☐	☐
Do you smoke?	☐	☐

Date:

Have you (had):	Yes	No
unusual clotting factors?	☐	☐
heart or circulatory disorders (high blood pressure)?	☐	☐
blood disease?	☐	☐
diabetes?	☐	☐
asthma, hay fever?	☐	☐
osteoporosis; other bone conditions?	☐	☐
allergies (e.g. penicillin, iodine)?	☐	☐
yellow fever, AIDS, HIV+?	☐	☐
used drugs?	☐	☐
epileptic seizures?	☐	☐
any other serious illnesses?	☐	☐
one or more prothesis?	☐	☐
Are you pregnant?	☐	☐
Do you have special treatment risks?	☐	☐
(e.g. do you have a pacemaker; do you need pre-medication?)		

send form

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