

Patient Last Name, First Name, Address

# Patient Questionnaire

Date of Birth:

Email:

Phone (home): .....

(Work): .....

Occupation/Employer: .....

Primary Physician: Name: .....

Address: ..... Phone: .....

Please answer the following questions about your state of health as accurately as possible. This information is subject to medical privacy and data protection laws and will be handled with strict confidentiality.

### Heart/cardiovascular diseases:

- High blood pressure  Yes  No
- Low blood pressure  Yes  No
- Heart valve disease  Yes  No
- Heart valve replacement  Yes  No
- Pacemaker  Yes  No
- Endocarditis  Yes  No
- Heart surgery  Yes  No

- Severe neutropenia  Yes  No
- Cystic fibrosis  Yes  No
- Organ transplant  Yes  No
- Stem cell transplant  Yes  No

### Infectious diseases:

- HIV/AIDS  Yes  No
- Liver disease/Hepatitis  Yes  No
- Tuberculosis  Yes  No
- Other infectious diseases  Yes  No

Are you pregnant?  Yes  No  
 If yes, what month? .....month

- Epilepsy  Yes  No
- Asthma/lung diseases  Yes  No
- Blood clotting disorders  Yes  No
- Diabetes  Yes  No
- Drug dependency  Yes  No
- Nerve disease  Yes  No
- Kidney diseases  Yes  No
- Fainting spells  Yes  No
- Osteoporosis  Yes  No
- Smoker  Yes  No
- Rheumatism/arthritis  Yes  No
- Thyroid disease  Yes  No
- Other diseases:  Yes  No

### Allergies or intolerances:

- Local anesthesia/injections  Yes  No
- Antibiotics  Yes  No
- Pain medication  Yes  No
- Metals: .....

Have you had dental x-rays?  
 If yes, when? .....

Which medication do you take regularly or are currently taking? ..... since .....

- Do you take bisphosphonates?  Yes  No since .....
- Are you receiving chemotherapy medication?  Yes  No since .....
- Are you receiving radiation therapy for cancer?  Yes  No since .....
- Are you taking high-dosage steroids / immunosuppressants?  Yes  No since .....

I hereby authorise the electronic storage, processing and use of my data for input in the Recall System.

I agree to immediately report any and all changes arising during the entire treatment period. I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

**In the case of extensive services by dentists or dental technicians for which my dentist is obliged to make payment in advance, I understand that a credit check may be carried out by a credit protection or credit reporting agency.**

Location: ..... Date: .....

Signature: .....