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:			**Epilepsy**	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	**Asthma/lung diseases**	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No	**Blood clotting disorders**	☐ Yes	☐ No
Heart valve disease	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
Heart valve replacement	☐ Yes	☐ No	**Drug dependency**	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	**Nerve disease**	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No	**Kidney diseases**	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	**Fainting spells**	☐ Yes	☐ No
			Osteoporosis	☐ Yes	☐ No
Severe neutropenia	☐ Yes	☐ No	**Smoker**	☐ Yes	☐ No
Cystic fibrosis	☐ Yes	☐ No	**Rheumatism/arthritis**	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No	**Thyroid disease**	☐ Yes	☐ No
Stem cell transplant	☐ Yes	☐ No	**Other diseases:**	☐ Yes	☐ No
			……		

Infectious diseases:			**Allergies or intolerances:**		
HIV/AIDS	☐ Yes	☐ No	Local anesthesia/injections	☐ Yes	☐ No
Liver disease/Hepatitis	☐ Yes	☐ No	Antibiotics	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Pain medication	☐ Yes	☐ No
Other infectious diseases	☐ Yes	☐ No	Metals: ……..		

Are you pregnant?	☐ Yes	☐ No	**Have you had dental x-rays?**	
If yes, what month?	.....month		If yes, when?	

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