ZAHNARZTPRAXIS ZÜRICHSEE

REGISTRATION FORM / HEALTH QUESTIONNAIRE

last name………………………………………… first name…………………………………………………………

zip code/city……………………………………… street ………………………………… no..…………………

date of birth……………………………………… hometown……………………………… nationality…………

home phone no.…………………………………business phone no.………………………cellular phone……..

parents/legal representative…..……………………………………………………………………………………

employer……………………………………… profession…………………………………………………………

general practitioner……………………………… city………………………………………… phone………………

health insurance………………………………… accident insurance……..…………………………………………

concern……….………………………………………………………………………………………………………

In order to advise you personally and to apply any possible medication for your protection correctly, we need certain specifications regarding your health.
All your information is subject to our doctor's duty of confidentiality. Please check where applicable.

	yes	no
¬ Have you been hospitalized or undergone medical treatment within the last 3 months?……............	☐	☐
If yes, why?…………………………………………………………………………...	☐	☐
¬ Do you take any medication regularly?...………………………………………………………………………		
If yes, which? ………………………………………………..…………………………………………..		
¬ Is your blood diluted or do you tend towards long bleeding? ……………………..	☐	☐
¬ Do you suffer from a cardiac defect or a heart disease?……………………..	☐	☐
¬ Is your blood pressure high? …………………………………………………………………………………	☐	☐
¬ Did you ever have any unusual reactions (allergies etc.) to nourishments, pharmaceuticals, dental materials etc.?…………………………………………………………………………………………	☐	☐
¬ Have you ever suffered from or are you currently suffering from the following diseases:		
Asthma or hay fever?……………………………………………………………………………….	☐	☐
Diabetes? ……………………………………………………………………………………….	☐	☐
Epilepsy?………………………………………………………………………………………....	☐	☐
Frequent headaches?…………………………………………………………………………………	☐	☐
Gastro-intestinal diseases? ………………………………………..…………………………	☐	☐
Rheumatism or arthrosis/arthritis?…………………………………………………………………	☐	☐
¬ Have you ever been in therapeutic radiology?………………………………………………………………	☐	☐
¬ Did you ever have or do you have yellow fever (hepatitis) or any other serious infectious disease (AIDS, tuberculosis etc.)?...........………………………………………………………………………………	☐	☐
¬ Female patients: Are you pregnant?……………………………………...…................................	☐	☐
¬ Do you attach importance to the appearance of your teeth?……………………………………………	☐	☐
¬ Do you wish to have fillings done in the color of your teeth or reconstructions?……………………..	☐	☐
¬ Would you like a reminder SMS for your appointments?..	☐	☐

¬ I have been referred to by ……………………………………………………………………………………………..

The undersigned agrees to the collection procedure of the dental fees (including future treatments) being undertaken by a collection agency. The necessary data for this purpose may be passed on to the collection agency by the dentist.

date……………………………………………… signature