**Personal Details and Medical History**

Welcome!

Thank you for your interest in our dental practice.

We look forward to having you as a client.

# Personal Details

|  |  |
| --- | --- |
| Last name  |   |
| First name  |   |
| Title (Mr, Mrs, etc)  |   |
| Street address  |   |
| Postcode and town  |   |
| Date of birth  |   |
| Telephone Home Business Mobile  |   |
| E-mail address  |   |
| Marital status  |   |
| Nationality  |   |
| Occupation  |   |
| (Children) Full name of parent or guardian  |   |
| Accident insurance  |   |
| Health insurance: provider and membership number  |   |
| AHV number  |   |
| Referred / recommended by  |   |
| Name and address of family doctor (GP)   |   |

#  Medical History

Please cross Yes or No as appropriate

|  |
| --- |
| **1**  |
| **2**  |
| **3**  |
| **4**  |
| **5**  |
| **6**  |
| **7**  |
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| **12**  |
| **13**  |
| **14**  |
| **15**  |
| **16**  |

 Have you recently been treated by a doctor?  Yes  No

If so, for what illness?

 Are you currently taking medicine of any kind? If so, please specify:  Yes  No

Do you have, or have you ever had, hepatitis (jaundice, liver inflammation)?  Yes  No

 Are you HIV-positive or suffering from AIDS?  Yes  No

 Do you have, or have you ever had, any other infectious diseases?  Yes  No

 Do you have any allergies? If so, please specify:  Yes  No

* Do you have an Allergy Pass?  Yes  No
* Do you react adversely to injections or particular medicines  Yes  No

(e.g. antibiotics)? If so, which ones?

 Do you smoke?  Yes  No

 If so, how many cigarettes per day?

 Are you an ex-smoker?  Yes  No

Do you suffer from pain or tension in the jaw joint or muscles (headaches  Yes  No in the morning)?

 Have you ever damaged your teeth in an accident?  Yes  No

 If so, did you consult a dentist?  Yes  No

 Do you have, or have you ever had, sinusitis?  Yes  No

 Do you have any artificial joints, or a pacemaker, or other implants?  Yes  No

 (Women) Are you currently pregnant?  Yes  No

If so, in which week?

Do you suffer from abnormal bleeding?  Yes  No If so, do you take blood-thinning medicine?  Yes  No

Blood test values (Quick, INR):

 Do you suffer from epilepsy or glaucoma?  Yes  No

 Do you suffer from any other serious complaint?  Yes  No

If so, please specify:

|  |  |  |
| --- | --- | --- |
| **Administration**  |   |   |
| Would you like to receive all correspondence and quotations by e-mail?  |  Yes  |  No  |
| Would you like to receive bills by e-mail?  |  Yes  |  No  |
| Do you receive supplementary benefits (Ergänzungsleistungen) from the Swiss compensation office (Ausgleichkasse)? If so please provide the name of the responsible case worker:   |  Yes  |  No  |
| Do you receive benefits from a Swiss social service? If so, which department?  |  Yes  |  No  |
| Are you under adult protection (official guardianship)? If so, please specify name and telephone number of your official guardian:  |  Yes  |  No  |

# Consent

I agree that any medical records held in this practice and created by the previous owner, Dr Guido Macek, may be **inspected** by Dr Claude Rast, to whom ownership of the practice has been transferred, and **used by him** in his capacity as **dental treatment provider**.

Lucerne, on (date): Signed:

I agree that my medical history, plus diagnostic findings including x-rays and photographs, copied or printed out as necessary, may be exchanged with my family doctor or other personnel bound by medical confidentiality for the purposes of such medical clarifications or opinions as may be required for my treatment; and that any data necessary for billing, payment, and accounting may be forwarded to the organisations concerned.

I agree that, when necessary, a local anaesthetic may be administered to me. I understand that this may rarely give rise to irritation (numbness, tingling) of the lower jaw and tongue, a condition which is normally only temporary. I am aware that for several hours after dental or surgical procedures under local anaesthetic the operation of a motor or other vehicle may be attended by an increased risk of accident.

Lucerne, on (date): Signed:

**Payments may conveniently be made using any of the usual EC debit cards (EC-Karte) except PostCard.**

In this case you will of course still receive the bills and receipts you need for your records (health insurance, tax, etc).

*Many thanks for completing this questionnaire!*

Your Care Team at the

"Dentist on the Schwanenplatz" (Zahnarzt am Schwanenplatz GmbH)