ZAHNARZT DR. WEISS
und Kompetenzpartner für
Orale Medizin und Zahnmedizin
für jedes Alter | Walchwil

Dorfstrasse 4 | info@weisszahnarzt.ch
6318 Walchwil | www.weisszahnarzt.ch

Personal Information and Medical History

Surname: _____ First Name: _____

Street, Nr.: _____ Zip Code, Town: _____

Date of Birth: _____ Occupation: _____

Tel. Privat: _____ Tel. Business: _____

Mobile: _____ E-Mail: _____

Dentist: _____

Doctor: _____

Referral to our Practice: Doctor ☐, Dentist ☐, Other ☐, Name and Adress: _____

What is the reson for your visit?

Pain ☐, Consultation ☐, Second Opinion ☐, Accident ☐, Other ☐: _____

How were you referred to our Practice?

Family/Friend ☐, Advertisement ☐, Lecture ☐, Internet ☐, Other ☐: _____

Do you receive Welfare or Social Benefits? Needs-based Minimum Benefits –AHV/IV ☐, Financial Government Support ☐

How would you like to receive your Dental Account: via E-Mail ☐, Appointment Reminder: SMS ☐ or E-Mail ☐

Name and Section of your Health Insurance: _____

AHV-Nr.: _____

Legal Guardian: _____

Surname, First Name and Address: _____

Dental Questions:	**J**	**?**	**N**
Are you experiencing Dental Pain: Tooth ☐, Gums ☐, Upper ☐ or Lower Jaw ☐?	☐	☐	☐
Do you suffer from Mouth Ulcers ☐, Cold sores ☐, Inflammation of the Soft Tissues ☐, Dry Mouth ☐, Burning sensations in the mouth ☐, Changes in the Soft tissues ☐, Ill-fitting Denture ☐, Other ☐: _____ How often? Daily ☐, Several times per week ☐, occasionally ☐	☐	☐	☐
Have you ever had a Tooth or Jaw related accident?	☐	☐	☐
If yes, was there an Accident Report issued to the Insurance Company?	☐	☐	☐
Do you clench or grind your Teeth?	☐	☐	☐
Do you suffer from Headaches, Neck or Shoulder pain? (please specify) _____	☐	☐	☐
Do you suffer from Bad Breath?	☐	☐	☐
Do you use the following: Dental Floss ☐, Interdental Brush ☐, Mouthwash ☐, Other ☐: _____ How often? Daily ☐, Several times per week ☐, Occasionally ☐	☐	☐	☐
What was your previous Recall interval? 6 months ☐, Yearly ☐, Spontaneous ☐	☐	☐	☐
When was your last Dental Consultation? _____	☐	☐	☐
Reason for your last Dental Consultation: Pain ☐, Other ☐: _____	☐	☐	☐
Have you ever been treated by a Dental Hygienist?	☐	☐	☐
Have you ever had any adverse reactions to Dental Treatment ? Pain /Swelling ☐, Bleeding ☐, Intolerance to Dental Materials ☐, Ill-Fitting Prosthetics (Denture/crowns etc) ☐, Fear ☐, Other ☐: _____	☐	☐	☐

General Medical Questions:	**J**	**?**	**N**
Are you currently under Medical Supervision?	☐	☐	☐
Have you had Medical Treatment in previous 12 Months?	☐	☐	☐
Have you had any Medical treatment in a Hospital environment in the last 5 Years? If Yes, what for? _____	☐	☐	☐
Do you take any Medication, Suppliments?	☐	☐	☐

Please list all Medications, Suppliments on the next Page provided!

Please turn the Page!

Do you have any of the following
Please tick the appropriate response

Heart / Blood / Circulation:	**J**	**?**	**N**
- High / Low Blood Pressure?	☐	☐	☐
- Heart or Chest pain while peforming Physical Activities (Angina pectoris)?	☐	☐	☐
- Dizziness?	☐	☐	☐
- Fainting?	☐	☐	☐
- Irregular Heart beat?	☐	☐	☐
- Heart Attack?	☐	☐	☐
- Stroke?	☐	☐	☐
- Shortness of Breath?	☐	☐	☐
- Congenital Heart defect?	☐	☐	☐
- Endocarditis?	☐	☐	☐
- Pacemaker?	☐	☐	☐
- Heart / Cardiac Valve operation?	☐	☐	☐
Respiratory Diseases:			
- Sinusitis?	☐	☐	☐
- Angina?	☐	☐	☐
- Chronic Bronchitis / Lung Infections?	☐	☐	☐
- Blood by Coughing??	☐	☐	☐
- Tuberculosis?	☐	☐	☐
- Do you Snore?	☐	☐	☐
Blood Disorders:			
- Blood disease – when yes, what? _____	☐	☐	☐
- Anemia?	☐	☐	☐
- Dialysis?	☐	☐	☐
- Blood Thinners (z. B. Marcoumar, Sintrom)?	☐	☐	☐
Allergic Reactions:			
- Asthma?	☐	☐	☐
- Hey fever?	☐	☐	☐
- Skin Rashes?	☐	☐	☐
- Hypersensitive ractions from Medication (e.g. Local Anesthesia) ☐, Penicillin ☐, other Antibiotics ☐, Iodine ☐, Sulfonamide ☐, Pain medications ☐, Food ☐, Pollen ☐, Dust ☐, Metal ☐, Plastics ☐? Other ☐ _____	☐	☐	☐
Rheumatic and / or Joint Diseases:			
- Arthritis?	☐	☐	☐
- Rheumatism – Swollen joints?	☐	☐	☐
- Artifical Joint Replacement?	☐	☐	☐
Chronic Pain?			
- Headaches, Migraine	☐	☐	☐

Metabolic Diseases:	**J**	**?**	**N**
- Diabetes (Diabetes mellitus)?	☐	☐	☐
- Thyroid Disease?	☐	☐	☐
- Prolonged Healing?	☐	☐	☐
- Hormone Imbalance, Hormone Therapy?	☐	☐	☐
Neurological / Mental Disorders:	☐	☐	☐
- Dementia?	☐	☐	☐
- Depression?	☐	☐	☐
- Morbus Parkinson?	☐	☐	☐
- Epilepsy?	☐	☐	☐
- Multiple Sclerosis (MS)?	☐	☐	☐
Other Medical Disorders:	☐	☐	☐
- Eye Disorders?	☐	☐	☐
- Hearing Disorders, Tinnitus?	☐	☐	☐
- Kidney Disease?	☐	☐	☐
- Kidney Failure?	☐	☐	☐
- Gastro-intestinal Disorders (e.g Ulcers)?	☐	☐	☐
- Liver Disease (Hepatitis)?	☐	☐	☐
- Osteoporosis?	☐	☐	☐
- Tumors?	☐	☐	☐
- Tumor-Therapy with Medication (Chemotherapy) or Radiotherapy?	☐	☐	☐
- Tumor- or Osteoporosis-Therapy with Bisphosphonates	☐	☐	☐
- Hereditary Disease?	☐	☐	☐
- Have you ever been tested for HIV? If yes, when? _____	☐	☐	☐
- Do you take Drugs?	☐	☐	☐
- Do you smoke? What ? _____ How many? _____	☐	☐	☐
- Do you regularly consume Alcohol?	☐	☐	☐
- Smoke-free Tobacco (Snus)?	☐	☐	☐
Health Cards, Passes, Certificates:	☐	☐	☐
- Blood Thinners, Allergies, Endocarditis etc	☐	☐	☐
For Female Patients:			
- Are you pregnant?	☐	☐	☐

I agree to provide information to a Third Party for Medical Purposes. This includes Medical History, Radiographs, Photographs and Diagnostic Findings. All information will be adhered to and maintained with strict Medical Confidentiality.
I agree to provide information to relevant Institutions for Invoicing, Accounting and Collections. All information will be conducted and maintained with strict Confidentiality.

Date: **Signature: Patient** **Date:** **Revised by:**