DR. JENS TARTSCH
SWISS DENTAL HEALTH

General Questionnaire

Dear patient,
We are pleased to welcome you in our practice! To ensure a individual advice and support, we ask you to answer the following questionnaire. Please note also the backside of this sheet! Please inform us about essential changes of your health status.

If you have any questions, please contact your practice team at any time!

Personal data (subject to medical confidentiality)

Patient ____
Name first name date of birth

Representative/parents ____
Name first name date of birth

Address ____
Street / Nr. Zip / Postal code

Contact ____
Phone. private phone. business. mobile **e-mail**

Profession ______________________ *Employer* ______________________

Invoice receiver:* Private ❑ sickness-/ accident insurance ❑ social services/ IV reciepients ❑
* (if here no specifications were made, the invoice is created "Private", subsequent changes shall be borne by the patient)

General questions

1. What is the reason for your visit?
Tooth pain ❑ general check up ❑ esthetics ❑
Dental hygien ❑ UmweltZahnMedizin ❑ general check up ❑
others______________________________________

2. How did you hear about our dental office?
Office sign ❑ phone book ❑ Internet ❑ recommended by ____________________
others______________________________________

3. My last dentist visit was before _____ months/years, at __________(estimated date month/year)

4. How much do you value your fear of dental treatment?

❑ Yes, very much (6) ❑ (5) ❑ (4) ❑ (3) ❑ (2) ❑ No, none(1)

5. Do you wish the inclusion in our back order system (recall) ? Yes ❑ No ❑

Declaration

With your signature, you confirm the accuracy of your data and you agree that your data can be used for internal purposes of the dental office Dr. Jens Tartsch as well as using for external purposes as contacting third parties involved, such as dental laboratory, referring physician, assignments to third parties, insurance companies, social authorities. You allow Dr. Tartsch by your signature if necessary to send and request medical reports to / from doctors involved in your treatment.
Hereby you agree, that the billing and collection of dental fee - also for future treatments - can be done through billing companies. For this purpose the required data may be distributed at the respective places. You aware, that some services within the framework of the UmweltZahnMedizin will not be taken over by the aid agencies or health insurance companies. This statement applies, until it is revoked.

Date _____________ **Signature**____________________________

Please turn

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Questions on General diseases (anamnesis)

Are you currently undergoing medical treatment? Yes ☐ No ☐

If yes: Name of doctor________________________ discipline ___________ location__________

Are you currently pregnant? Yes ☐ No ☐

Do you take blood-thinning or anticoagulant medications? Yes ☐ No ☐

If yes, which one? : _____________________________

Do you take bone effective medications (Bisphosphonate) ? Yes ☐ No ☐

If yes, which one? : _____________________________

Do you suffer from chronic diseases or pain? Yes ☐ No ☐

If yes, which one? : _____________________________

Do you suffer from osteoporosis (bone loss)? Yes ☐ No ☐

Because of which diseases are ore were you treated?

Heart disease	Heart attack	Yes ☐ No ☐
	Endocarditis (heart valves/pouch inflammation	Yes ☐ No ☐
	Pacemaker	Yes ☐ No ☐
	Angina Pectoris (Heart asthma)	Yes ☐ No ☐
Cardiovascular disease	high / low blood pressure	Yes ☐ No ☐
	Fainting spells	Yes ☐ No ☐
Metabolic diseases	Diabetes	Yes ☐ No ☐
Nervous system	Epilepsy	Yes ☐ No ☐
Blood diseases	Bleeding tendency ("hemophilia")	Yes ☐ No ☐
Allergies	Eczema	Yes ☐ No ☐
	Asthma	Yes ☐ No ☐
	Allergy pass	Yes ☐ No ☐
	Penicillin- Hypersensitivity	Yes ☐ No ☐
	„Shot“- Hypersensitivity	Yes ☐ No ☐
	other Hypersensitivity against________________________	
Infectious diseases	Hepatitis / jaundice (Hepatitis A, B or C)	Yes ☐ No ☐
	Tuberculosis	Yes ☐ No ☐
	HIV-Infection	Yes ☐ No ☐

other diseases____

More Informations	are or have you been drugg addict?	Yes ☐ No ☐
	Have diseases of the eyes (narrow-angle glaucoma))	Yes ☐ No ☐
	Are you smoker?	Yes ☐ No ☐
	If Yes: how many cigarettes per day? ________________	

Date ______________ **Signature**______________________________