Zahnarztpraxis Maria Alevizacos
Warmly welcome to our practise!

Family Name, First Name (Patient) | Date of Birth: ☐ m ☐ f

Street Address | Zip, City, Country

Home Phone/Cell Phone | Work Phone

E-Mail | Profession

Insurance Company Name

Referring Physician - Name, Address, Phone

Family Doctor - Name, Address, Phone

If insured person is differing from patient mentioned above please fill in:

Family Name, First Name (insured person) | Date of Birth

Street Address | Zip, City, Country

Consent of Treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date | Parent/Legal Guardian Signature

Please, turn

Please answer the following questions regarding your state of health as exactly as possible:

State of Health	Please mark	Further Information
Cardiovascular Diseases:		
Hypertension	☐ Yes ☐ No	
Hypotension	☐ Yes ☐ No	
Valvular Heart Disease/Defect	☐ Yes ☐ No	
Endocarditis	☐ Yes ☐ No	
Heart Surgery	☐ Yes ☐ No	
Pacemaker	☐ Yes ☐ No	
Infectious Diseases:		
AIDS	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	
other:		
Allergies / Intolerances:		
Local Anesthetics	☐ Yes ☐ No	
Analgesics	☐ Yes ☐ No	
Antibiotics	☐ Yes ☐ No	
other:		
Further Diseases:		
Coagulation Diseases	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Lung Diseases	☐ Yes ☐ No	
Thyroid Diseases	☐ Yes ☐ No	
Rheumatism	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Nephropathy	☐ Yes ☐ No	
Fainting	☐ Yes ☐ No	
other:		
General Data:		
Drug Addiction	☐ Yes ☐ No	
Drinking of alcoholic beverages	☐ Yes ☐ No	If yes, ☐ seldom ☐ often ☐ regularly
Smoker	☐ Yes ☐ No	If yes, ☐ 0-10 ☐ over 10 cigarettes/day
Regular Medication/Drugs	☐ Yes ☐ No	If yes, since when / Name:
X-Rays taken before	☐ Yes ☐ No	If yes, Date / Body Parts:
Gravidity/Pregnancy	☐ Yes ☐ No	If yes, what month:
Recall	☐ Yes ☐ No	

How did you get informed about our dentist's practice?

Important Information:

All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electronically.
I engage myself to inform you immediatelly about all changes occuring during the period of treatment.
I engage myself to keep agreed appointments or to chancel them at least 1 days in advance, otherwise occuring costs can be invoiced.
I certify with my signature that I have read and understand all above printed **information**.

Date

Patient Signature and Parent/Legal Guardian Signature

Zahnarztpraxis Maria Alevizacos
Warmly welcome to our practise!

Please, turn