Name:
Adress:
Date/Place of birth:
Phone:
E-Mail:
Insurance:

ID 32 Identity 32 Zahnarztpraxis Dr. Pieger

Dr. Sascha Pieger, MSc.
Prosthodontist (DGPro)
Implantologist (DGI)

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Date:

Health Questionnaire

What is the purpose of your visit?
O Pain Management
O Restoration of teeth
O Consultation
O Repair of dentures
O Referral from _____

O **Yes** O **No**		**General Situation -** Please check boxes if indicated!
O	O	Do you have allergies? If yes, please specify?
O	O	Blood coagulation disorders
O	O	Heart diseases (i.e. high blood pressure, artificial heart valve etc.)
O	O	Diabetes (Type I, Type II)
O	O	Osteoporosis
O	O	Respiratory diseases (Asthma, Bronchitis)
O	O	Gastrointestinal diseases (i.e. Morbus Crohn)
O	O	Liver diseases
O	O	Kidney diseases
O	O	Thyroid diseases (i.e. Hyper-; Hypothyreosis)
O	O	Eye diseases (i.e. Glaucoma)

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Yes	No	**General Situation -** Please check boxes if indicated!
○	○	Skin diseases (Eczema)
○	○	Tumor diseases (Where? When?)
○	○	Infections (Hepatitis, Tuberkulosis, HIV)
○	○	Psychosomatic diseases (i.e. Depression)
○	○	Do you smoke?
○	○	Do you drink alcohol?
○	○	Females: Are you pregnant?
○	○	What medications are you taking at present? _____
○	○	Are you currently receiving medical treatment?

Yes	No	**Special Situation -** Please check boxes if indicated!
○	○	Do you suffer pain in the mouth or at teeth?
○	○	Do you suffer gum bleeding?
○	○	Do you suffer the feeling of bad breath?
○	○	Are you satisfied with the aesthetics of your teeth?
○	○	Do you suffer from pain in the head-, throat- or shoulder area?
○	○	Have you been visiting a dentist in the past 2 years?
○	○	Where x-rays taken? If yes please specify the year:_____
○	○	When was the last professional dental cleaning? _____

I consent to, that my data is being stored electronically and processed to fulfil the contractual obligations. Also to that the processing and forwarding of my personal data (name, insurance, x-rays, models) to external physicians, dental laboratory's and insurances.

Date:_____

Signature:_____