Patient Data Sheet

(Please Print All Information)

Family Name, First Name (Patient)	Date of Birth, Sex: ☐m ☐f
Street Address	Zip, City, Country
Home Phone / Cell Phone	Work Phone
E-Mail	Profession
Insurance Company Name	
Reffering 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 min is required:

Date	Parent / Legal Guardian Signature

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			
Endocarditis	☐Yes	☐No	
Heart Surgery	☐Yes	☐No	
Pacemaker	☐Yes	☐No	
Infectious Diseases:			
AIDS		☐Yes	
Hepatitis		☐Yes	
Tuberculosis	☐Yes	☐No	
other:			

Allergies / Intolerances:	**Please mark**		**Further Information**
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	
orther:			

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:

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 immediately about all changes occurring during the period of treatment.
- I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occurring 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