Dentius

Last name + First name ____________________

Address ____________________

Email ____________________

Phone number: ____________________

Name general practitioner & phone number : ____________________

## 1. Do you have any of the following health problems? If yes, please mark.

- ☐ Heart
  - o Pacemaker/diagnostic device
  - o Leaking heart valve
  - o Squeezing feeling in the chest
  - o Artificial heart valve
- ☐ Lungs
  - o Asthma
  - o Hyperventilation
- ☐ Diabetes
  - o Type 1
  - o Type 2
- ☐ High/ low blood pressure
- ☐ Recent hip/knee prosthesis
- ☐ Bleeding tendency (e.g., spontaneous bruising, long bleeding after tooth extraction)
- ☐ Sero-positive/HIV
- ☐ Liver
- ☐ Stomach-Intestine
- ☐ Kidneys
- ☐ Tumors, date of diagnosis ____________
  - o With chemo
  - o With radiation
  - o With continued medication
- ☐ Epilepsy
- ☐ Thyroid
- ☐ Hepatitis A / B / C

Specialist who treats you:

Medication you are taking for this condition: ____________________

## 2. Are you taking any of the following medication? If so, which ones?

Bisphosphonates (bone enhancer) ____________________

Blood thinners ____________________

## 3. Are you allergic to certain medication or products? If so, which ones?

____________________

## 4. Other information. Circle what fits.

| | |
|---|---|
| Do you suffer from fainting during dental treatment/anesthesia? | Yes/No |
| Are you potentially pregnant? | Yes/No/number of weeks: |
| Do you smoke? | Yes/No number of pieces per day: |
| Have you been vaccinated against Covid-19? | Yes/No/ when? : |

When did you go to the dentist for the last time? ____________________

How did you find us? ____________________

Do you have an additional dental insurance? If so, which one? ____________________

The patient gives permission for his/her data to be used for communication in the context of treatment.

Date: Signature: