



# VICARI

## Zahnarztpraxis

Patient  
Woman / Man / Child

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Name	First Name
Street	Number
Postcode	Place
Date of Birth	Phone-Number

Payer \*

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Name	First Name
Street	Number
Postcode	Place
Date of Birth	Phone-Number

Insurance

- private Insurance
- member of a statutory health Insurance
- additional Insurance

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Job of the payer\*

Employer

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Address of the employer (Street, Place, Telefon)

**For your medical chart we request the following information which of course fall under the doctor-patient-privacy-act. Please contact us if there are any changes in your state of health or your private contact details.**

1. Do/Did you have any of these following deseas?

a) Serious breathlessness  yes  no

b) Allergic reaction like hay fever  yes  no

c) Drug incompatibility  yes  no

which one? \_\_\_\_\_

d) Blood pressure  high  normal  low

Blood pressure reading? \_\_\_\_\_

e)  Stroke  Paralysis

Cardiac infarction or Cardiac disease  no

when? \_\_\_\_\_

f)  Icterus  Liver Diseas

HIV-Infection  no

when? \_\_\_\_\_

g) Diabetis  yes  no

h) Rheumatism  yes  no

i) Blood diseases  yes  no

Coagulopathy  yes  no

j) Circulatory diseases  yes  no

k) Nephropathy diseases  yes  no

l) Thyroids diseases  yes  no

m) Epilepsy  yes  no

n) Dry Alcoholic  yes  no

2. Do you have a cardiac pacemaker?  yes  no

3. Do you suffer from gum bleeding?  yes  no

4. When has been your last X-Ray examination? \_\_\_\_\_

5. Do you take presently / regulary drugs?  yes  no

Which drugs? \_\_\_\_\_

6. Pregnancy?  unsure  yes  no

In which week? \_\_\_\_\_

7. Other information / other diseases

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**May we remind you of your Check-Up Appointments?**  yes  no

**Do you have any wishes concerning your treatment?**

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**Do you like to get an advice concerning Dental Health?**

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**What advised you of us?**

- Newspaper  MDH
- Internet
- Advice of who? \_\_\_\_\_
- Others \_\_\_\_\_

**Dear patient,**

in order to minimize waiting time we run our practice with an appointment making system. If you are not able to keep your appointment, we would kindly ask you to cancel it 24 hours in advance. Otherwise we will have to charge you for the procedures and the unused time. If you get your appointment at short notice, waiting time might occur. Also, in case of an emergency we can only offer you an emergency treatment.

**Important for members of statutory health insurance schemes:**

Please submit the medical insurance card at least ten days after the beginning of treatment. If not, we will have to bill you privately.

With my signature I check the correctness and completeness of my information.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sign of the payer\*

\* Payer = Recipient invoice, with legal coindured set the patient up, with minor the legal representative