Welcome!

Please fill out this form using block capitals and tick the box where appropriate.

Surname, first name | Date of birth, Place of birth | ☐ m ☐ f ☐ d

Street and no. | Zip code / city

Landline | Mobile phone | E-mail

☐ Public health insurance: ____________________

☐ Private health insurance: ____________________

☐ Aid / subsidy

☐ Dental supplementary insurance

For minors: surname, first name of legal guardian | Date of birth

Family insured through: surname, first name | Date of birth | Address

State of health

☐ Asthma

☐ High blood pressure

☐ Pacemaker

☐ Heart valve defect

☐ Tumour disease

☐ Epilepsy

☐ Diabetes

☐ Glaucoma

☐ Smoker

☐ Frequent consumption of alcohol or other narcotics

☐ Other: ____________________

☐ Allergies: ____________________

☐ Infectious diseases:

☐ Cardiovascular diseases: ____________________

☐ Blood thinner: ____________________

☐ Other medications (esp. biphosphonates):

☐ Drug intolerance: ____________________

☐ Surgery in the past 12 months and / or prospective surgery in the coming year:

☐ Pregnant / due date:

How did you find us?

☐ Internet:

☐ Personal recommendation:

☐ Other:

I hereby confirm that the information provided above is accurate to the best of my knowledge. In case my personal data changes, I will inform the practice as soon as possible.

✕ ____________________

date / signature