Ord. Dr. Barbara Minihold
FÄ für Zahn,- Mund,- Kieferheilkunde
Hauptstraße 38/J. Thomastr. 3
2340 Mödling
Tel 02236/242 83 Fax DW 20

APPLICATION FOR DENTAL TREATMENT

Patient's details

Name: _____

Health Insurance No.: | | | | | | | | | | |
Number Day Month Year

Address: _____
Street Number

_____
Postcode Town

Tel. No (home&mobil): _____

E-mail: _____

Med. Insurance Comp.: _____

Employer: _____

_____
Postcode Town

Tel. No Office: _____

Insured with

Name: _____

Health Insurance No.: | | | | | | | | | | |
Number Day Month Year

Who recommended us to you?

_____

Dear Patient,

All personal information given to us is treated as **strictly private and confidential.** Please answer the following questions about your state of health to help us know how to best advise and treat you.

Why are you seeking dental treatment? _____

_____

Are you in pain? Yes ❑ No ❑

Do you suffer from: (please tick as appropriate)

❑ Fainting attacks ❑ High Blood Pressure ❑ Heart Disease
❑ Diabetes ❑ Epilepsy ❑ Rheumatism
❑ Infectious Diseases ❑ Hepatitis ❑ HIV
❑ Bleeding Disorder ❑ Pace Maker ❑ _____
❑ **Blood Thinning Medication**:
❑ Marcoumar ❑ Thrombo ASS ❑ _____

Are you pregnant: Yes ❑ No ❑

Are you taking any prescribed medicine? Yes ❑ No ❑
If so give details: _____

_____

Are you allergic to anything? Yes ❑ No ❑
If so what are you allergic to: _____

_____

Further Information: _____

Do you smoke? Yes ❑ No ❑
Do you suffer from gum bleeding? Yes ❑ No ❑
Do you suffer from TMJ disorders? Yes ❑ No ❑
Do you require professional tooth cleaning? Yes ❑ No ❑
May we invite you in case you need one? Yes ❑ No ❑

Please note that any medication (including local anaesthetics) given to you before, during or after dental treatment may impair your driving abilities.

Mödling, am _____ _____
Date Signature