Fachärzte für Mund-, Kiefer-und Gesichtschirurgie und Fachzahnärzte für Oralchirurgie
Dr. med. Dr. med. dent. Thomas Beck Dr. med. dent. Alexander Schmermund
Dr. med. Lutz Birkenhagen Facharzt für Anästhesie
Dr. med. Dr. med. dent. Christoph Peters Dr. med. Anton Klaus Spitzer

Praxis & Klinik FÜR KIEFER GESICHT

	Pat. Nr.:

NET-Cert e.V. Zertifizierte s QM

Patient Last Name First Name	Relationship to Sponsor □ Self □ Spouse □ Child □ Other	Sex □ Male □ Female
Patient Date of Birth Day / Mo / Year	**Sponsor SSN:**	
Patient Residence Address: Home dentist:	Home Phone: Cell Phone: Fax:	
Name of Group Dental Program **Tricare** Dental Program **(TDP)**	E-Mail: _____	
Sponsor Last Name First Name	**Sponsor** Date of Birth: Day / Mo / Year	
United Concordia (from 01.05.2017): □ Active Duty Family Member	□ command sponsored □ non command sponsored	

I certify that the Above Information is Correct:

Böblingen, _____
Date

_____
(Signature of Patient or Signature of Authorized Representative if Minor)

Please marc the following questions with an „ **X** „

		Yes	No
1.	Do you have or have you ever had heart problems (angina pectoris, myocardial infarction, cardiac arrhythmias)?	☐	☐
2.	Do you have a heart murmur, heart valve disease or an artificial heart valve?	☐	☐
3.	Have you ever had high blood pressure?	☐	☐
4.	Are you prone to haemorrhaging?	☐	☐
5.	Have you ever had a stroke?	☐	☐
6.	Do you have a seizure disorder (i.e. epilepsy)?	☐	☐
7.	Do you have bronchial asthma or any other lung disorders?	☐	☐
8.	Are you or have you ever been allergic to penicillin, aspirin, band aids or anything else?	☐	☐
9.	Do you have diabetes?	☐	☐
10.	Do you have a thyroid disease?	☐	☐
11.	Do you have a liver disease?	☐	☐
12.	Do you have a kidney disease?	☐	☐
13.	Have you ever had cancer or any virulent disease or leukaemia?	☐	☐
14.	Do you have a contagious disease?	☐	☐
15.	Have you ever fainted during a dental procedure?	☐	☐
16.	Are you required to take antibiotics before surgery (i.e. after a organ transplant, etc.)?	☐	☐
17.	Are you pregnant?	☐	☐
18.	Are you currently taking any medication? What kind? _____	☐	☐
19.	Have you ever had any surgery? What kind? _____	☐	☐

Böblingen, _____
Date

_____
(Signature of Patient or Signature of Authorized Representative if Minor)