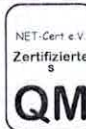


Fachärzte für Mund-, Kiefer-und Gesichtschirurgie und Fachzahnärzte für Oralchirurgie
 Dr. med. Dr. med. dent. Thomas Beck Dr. med. dent. Alexander Schmermund
 Dr. med. Lutz Birkenhagen Facharzt für Anästhesie
 Dr. med. Dr. med. dent. Christoph Peters Dr. med. Anton Klaus Splitzer

Pat. Nr.:



Patient Last Name Name	First	Relationship to Sponsor <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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 Name	First	Sponsor Date of Birth: Day / Mo / Year	
United Concordia (from 01.05.2017): <input type="checkbox"/> Active Duty Family Member		<input type="checkbox"/> command sponsored <input type="checkbox"/> non command sponsored	

I certify that the Above Information is Correct:

Böblingen, _____
 Date

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



Please mark 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)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a heart murmur, heart valve disease or an artificial heart valve?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you prone to haemorrhaging?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a seizure disorder (i.e. epilepsy)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have bronchial asthma or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you or have you ever been allergic to penicillin, aspirin, band aids or anything else?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had cancer or any virulent disease or leukaemia?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a contagious disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever fainted during a dental procedure?	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you required to take antibiotics before surgery (i.e. after a organ transplant, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you currently taking any medication? What kind?	<input type="checkbox"/>	<input type="checkbox"/>
19. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

Böblingen, _____
Date

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