DR. SALVADOR
CONGOST

ADMISSION FORM

Dear Patient:
We are pleased to welcome you at our dental office! Please complete all fields below relating to your person and health for our records. All information provided herein will be handled strictly confidential and in adherence to medical secrecy.

FIRST NAME, LAST NAME	DEGREE/TITLE	DATE OF BIRTH

STREET ADDRESS	POSTAL CODE	CITY/PLACE OF RESIDENCE

PROFESSION/BUSINESS	EMPLOYER

The following information is needed for urgent messages or calls:

PHONE (HOME)	PHONE (BUSINESS)

PHONE (MOBILE)	FAX	E-MAIL

General conditions may affect your dental treatment. We therefore kindly ask you to answer the following questions:

DO YOU OR DID YOU HAVE ANY OF THE FOLLOWING CONDITIONS/TREATMENTS?

Condition		
Heart valve disease / replacement	Yes	No
Cardiac pacemaker	Yes	No
Myocardial infarction (heart attack)	Yes	No
> Year		
Other cardiovascular conditions	Yes	No
Low blood pressure	Yes	No
High blood pressure	Yes	No
Asthma	Yes	No
Eye disorders	Yes	No
Drug intolerances	Yes	No
> Please specify		
Do you suffer from any other important disease?	Yes	No
> Please specify		

Condition		
Do you suffer from any infectious disease (e.g. HIV)?	Yes	No
Endocarditis	Yes	No
Bleeding (bood clotting) disorder	Yes	No
Joint replacement	Yes	No
Dialysis, kidney diseases	Yes	No
Liver diseases (e.g. hepatitis)	Yes	No
Diabetes	Yes	No
Rheumatic disease (e.g. arthritis, lupus, gout, scleroderma, fibromyalgia)	Yes	No
Epilepsy	Yes	No
Allergies or intolerances	Yes	No
> Please specify		

please turn over

Are there any drugs you take regularly? ☐ Yes ☐ No

> Please specify

Should we avoid the use of alcohol for disinfection in your case? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No

Do you currently receive dental treatment? ☐ Yes ☐ No

NAME AND ADDRESS OF YOUR FAMILY DOCTOR:

DENTAL HEALTH QUESTIONS

Did you have any accidents involving your face and/or skull? ☐ Yes ☐ No

Are you aware of bleeding gums? ☐ Yes ☐ No

Do you suffer from bad breath (halitosis)? ☐ Yes ☐ No

Have you noticed a metallic taste in your mouth sometimes? ☐ Yes ☐ No

Have you had orthodontic treatment? ☐ Yes ☐ No

Have you observed any tooth migration? ☐ Yes ☐ No

Do you feel that your teeth do not 'fit together' properly? ☐ Yes ☐ No

Do you experience discomfort when chewing? ☐ Yes ☐ No

Do you experience discomfort in the region of your temporomandibular joint/ear? ☐ Yes ☐ No

Have you had painful aching in your head and/or neck? ☐ Yes ☐ No

Do you feel uncomfortable with your teeth? ☐ Yes ☐ No

How high is the degree of your satisfaction with

... the appearance of your teeth? ☐ high ☐ medium ☐ low

... the current treatment of your teeth? ☐ high ☐ medium ☐ low

When was the last time an x-ray of your teeth was taken? > Year

Who recommended our office to you?

Please make sure to inform us in the case of any changes in your health status.

IMPORTANT: Please note that any drugs, including local anesthetic injections, may decrease your reactivity thus impairing your ability to participate in traffic.

KINSAU, DATE: SIGNATURE: