DR. FRIDLEIF BACHNER
FACHZAHNARZT FÜR ORALCHIRURGIE

Medical History

Dear Patient,

to provide the best medical treatment possible it is necessary to know your complete and truthful health history. Please answer the following questions and if you should have further Questions don`t hesitate to ask for our help. Thanks for your cooperation.

Versicherter (Insured person)

Vorname (Firstname)		Nachname (Lastname)	
Strasse u. Hausnummer (Adress)			
PLZ/Ort (City, ZIP Code)		Geburtsdatum (Date of birth)	
Tel. (Phonenumber)		Mobil (Mobile phone)	
Hausarzt (Generalpractitioner)		Zahnarzt (General dentist)	

Patient (if the insured person is the patient you don't have to fill out this part.)

Firstname		Lastname	
Adress			
City, ZIP Code		Date of birth	
Phonenumber		Mobilephone	
General practicioner		General dentist	

Do you have or have you had seizures, convulsions, epilepsy, psychiatric treatment? ☐ Yes ☐ No

☐ Lungdisease Diabetes	☐ Bleeding disorder, anemia,	☐ Heart attack
☐ Glaucoma	☐ bleeding tendency, medication with	☐ Heart surgery
☐ Stroke	☐ anticoagulants (bloodthinners)	☐ (pacemaker/ heart valves)
☐ HIV	☐ Kidney disease	☐ Congenital heart disease
☐ Hepatitis	☐ Thyroiddisease, goiter	☐ Any other surgery
☐ Liver disease	☐ High bloodpressure	☐ Allergic reactions

(only for women)

☐ are you pregnant or

☐ trying to become pregnant?

Please list all your regular medications:

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