Will be filled out from office

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Praxis für Mund-, Kiefer- und Gesichtschirurgie
Implantologie - Ästhetische Chirurgie

patient history form

phone (PRIVATE)		proffession	
phone (CELL)		GP	
phone (WORK)		dentist	
e-mail		dermatologist	

For patients under the age of 18 or family members, please note the principal member.

name		date of birth	
adress (if divergent)			

pregnancy	no ◯	yes ◯
bloodthinner	no ◯	yes ◯

medication, please note:

Any known diseases?

	no / yes	which?
heart | blood pressure	◯ ◯	
blood coagulation disorder	◯ ◯	
lung | liver | kidney	◯ ◯	
diabetes | metabolism	◯ ◯	
osteoporosis	◯ ◯	
allergies | against drugs	◯ ◯	
HIV-positive | hepatitis | tuberculosis	◯ ◯	
other diseases?	◯ ◯	

I agree, according to §73 Abs.1b SGBV, that my data, findings and radiographs may be forwarded to my GP, family dentist or dermatologist.

no ◯ yes ◯

date _____ signature (patient) _____

13122042-20131030-301

Gesundheit hat Gesicht