STUDIO LUNGHI
Dr.ssa medico dentista SSO

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We warmly welcome you to our dental office.

As your health may affect dental treatment, please kindly fill in this form. Your data will be treated as strictly confidential and will be bound by professional secrecy. In case of questions we are at your disposal.

Patient ☐ f ☐ m

Surname: _____

Name: _____

Address: _____

Postcode, city: _____

Date of birth: _____

Email: _____

Tel. private: _____

Tel. mobile: _____

Tel. office: _____

Profession: _____

Employer: _____

Insurance

Health insurance: _____

Nr. insurance: _____

Do you receive: ☐ Social aid

Postcode, city: _____

Nr. AVS: 756. _____

☐ Supplementary benefits (AI/AVS)

Legal representative ☐ Parent ☐ Other:

Surname, name: _____

Address: _____

Postcode, city: _____

Tel. private: _____

Tel. mobile: _____

Tel. office: _____

Treating doctor

Surname, name: _____

Postcode, city: _____

Previous dentist

Surname, name: _____

Postcode, city: _____

Reason of the visit: _____

On the advice of: _____

Turn the page →

Health Questionnaire

1. Have you been recently ill, under medical treatment or in hospital? ☐ YES ☐ NO
If yes, due to what diseases? _____

2. Do you regularly take medications and/or drugs? ☐ YES ☐ NO
If yes, which ones? _____

3. Do you or did you smoke? ☐ YES ☐ NO
If yes, what and how much? _____

4. Do you suffer or have you already suffered from any of the following disorders? ☐ YES ☐ NO

- ☐ Allergy/Hypersensitivity (highlight the correspondents and/or specify):
  Pollen – Latex – Metals – Iodine – Food – Aesthetic – Medicaments
  Other: _____
- ☐ Hearth diseases (highlight the correspondents and/or specify):
  High pressure – Low pressure – Angina pectoris – Heart attack – Brain stroke – Cardiac defect/ Artificial valve – Heart rhythm disorders – Endocarditis
  Other: _____
- ☐ Blood diseases (highlight the correspondents and/or specify):
  Haemophilia – Anaemia – Other: _____
- ☐ Metabolic diseases (highlight the correspondents and/or specify):
  Diabetes – Hypothyroidism – Hyperthyroidism – Other:
- ☐ Infectious diseases (highlight the correspondents and/or specify):
  HIV – Hepatitis – Tuberculosis – Other: _____
- ☐ Liver or kidney diseases (specify): _____
- ☐ Stomach or intestinal diseases (specify): _____
- ☐ Respiratory or lung diseases (specify): _____
- ☐ Rheumatic or bone diseases (specify): _____
- ☐ Sinusitis, chronic facial pains or headaches (specify): _____
- ☐ Epilepsy or other brain disorders (specify): _____
- ☐ Depression or other disorders of the psyche (specify): _____
- ☐ Other (specify): _____

5. Have you already undergone surgery/operations? ☐ YES ☐ NO
If yes, which ones? _____

6. Have you already undergone chemotherapy or radiotherapy sessions? ☐ YES ☐ NO
If yes, why and when? _____

7. Do you have pacemakers, prostheses or other implants? ☐ YES ☐ NO
If yes, where? _____

8. Are you pregnant? ☐ YES ☐ NO
If yes, in what week? _____

Patient declaration

I acknowledge that, in the case of necessary clarifications, my clinical data may be exchanged with my treating doctors or with other entities underlying medical professional secrecy (such as insurance, etc.). I consent to forward the data necessary for invoicing, accounting and debt collection to the respective institutions. I agree that, if necessary, a local anesthetic is given to me, taking into account the possible side effects (swelling, pain or bleeding, rarely infections or tongue/jaw irritation, such as numbness or tingling). I note that a dental treatment under local anesthesia can increase the risk of accidents if I have to drive for several hours.

Place, date: _____ Signature: _____