Patient confidentiality form - anamnesis

This questionnaire gives your dentist important information about your health condition. These health data do not serve any purpose other than the provision of health care by DK Dent, s.r.o. and DK Hygiene s.r.o., and are subject to medical confidentiality. Contact details are used to establish your health card and for further communication with you - detailed information on the processing of personal data can be found at www.arbesdent.cz, section "Personal data", or www.arbesplus.cz - section "Personal data".

Personal details

Surname …… First name…….. Title……..

Date of birth. …… Insurance number…….. Health Insurance Company ……

Address…… Mobile/Phone ……..

E-mail…… Nationality……

Name, address and phone no. of your GP……

Alternate contact person if necessary, leave a message (illness doctor, rescheduling appointment etc.)

Name…… Mobile/Phone…….. E-mail……

Legal representative of a minor or incapacitated person

Name…… Mobile/Phone…… E-mail……

Health condition

1. Are you currently in progress getting any treatment? Yes No

What treatment?……

2. Have you been hospitalized in the last two years? Yes No

Reason?……

3. Are you currently taking or regularly taking any medications, incl. contraception? Yes No

What medications?……

4. Do you have or have had allergic or adverse reactions to medicines (eg. antibiotics) or anesthetics? Yes No

Specify ……

5. Do you have or have had allergic or adverse reactions to metals and other substances? Yes No

Specify……

6. Are you being treated or do you have any of the following diagnoses? If yes, please indicate:

□ Serious infectious diseases
□ Epilepsy
□ asthma
□ Allergies (drugs, food)
□ High blood pressure
□ Thyroid dinase
□ Lung disease (asthma, emphysema)
□ Diseases of the stomach and intestines ("ulcers", etc.)
□ Disorder of blood clotting (hemophilia)
□ Heart disease (angina pectoris, myocardial infarction, etc.)
□ COVID-19 (even if you only came in contact with an infected person)
□ Diabetes
□ Hepatitis A, B, C
□ HIV

Other diseases or treatment – specify:

……

7. Are you taking anticoagulants and antiaggregant (drugs to "blood thinners") – for example Warfarin, Anopyrin Yes No
Specify……

8. Are you pregnant? If yes, how many months? Yes No

……

9. Do you need antibiotic prophylaxis? (determined by a general practitioner or internist. Yes No
The reason……

10. Are you in the transplant program or have you undergone transplantation? Are you taking immunosuppressive medications?
…… Yes No

11. Have you had a head injury, teeth? Yes No
Specify……

12. Do you smoke? Yes / No Do you drink alcohol? Yes / No Are you taking drugs Yes / No

Dental care

1. The name of your last dentist

……

2. Was your last term of regular check-up for less than 6 months ago? Yes No

3. Was your last visit or treatment to another dentist less than 3 months ago? Yes No

4. Do you currently have toothache or another problem related to the oral cavity? If yes, please indicate:

□ Dryness in the mouth
□ Difficult biting, chewing, swallowing
□ Bruxism
□ The problem with the jaw joint
□ On going orthodontic treatment (braces)
□ Injuries to the teeth or jaws (excavation, knocked-out tooth, jaw fractures, etc.)
□ Overflowing with teeth, the teeth did not grow, not based (in the family)

Specify……

5. Do you prefer fewer visits and more treatments to be done during one appointment? Yes No

6. Have you ever been treated by a specialist in dental hygiene? Yes No

7. Do you have an extraordinary fear of dental treatment? (anxiety, phobias) Yes No

Where did you hear about us □ web □ FB □ printed media □ recommendation □ other:……

PLEASE BE AWARE OF OUR CANCELLATION POLICIES. ALL CONFIRMED APPOINTMENTS MUST BE CANCELLED AT LEAST 48H PRIOR TO THE SCHEDULED DATE. OTHERWISE, WE WILL CHARGE YOU CANCELLATION FEE ACCORDING TO THE CURRENT PRICE LIST.

I have informed myself and I agree with the conditions of the treatment, the price list of paid services, the guarantees and I agree.

I accept the conditions of personal data processing (GDPR).

I declare that the information I have given is true and I understand everything.

Date…… Signed by the patient / parent / legal representative……