

Health history / personal data

Please complete in capital letters

☐ Mr. ☐ Mrs./Ms.

Surname: _____ Given name: _____

Street and no.: _____ Postal code, city: _____

Date of birth (DD.MM.YYYY): _____ E-mail address: _____

Telephone (home): _____ Business: _____ Mobile: _____

ID / passport no.: _____ Nationality: _____

Profession: _____ Employer: _____

Health fund: ☐ Clalit ☐ Maccabi ☐ Meuhedet ☐ Leumit

☐ Private dental insurance ☐ Supplementary dental insurance ☐ Accident insurance ☐ Other

Surname, given name of parent or legal guardian (for minors): _____

Date of birth: _____

Referred by: _____

Your physician: _____

Please answer the following questions. All answers will be held in strict confidence.

1. Did you recently receive medical treatment or were you hospitalized? ☐ yes ☐ no

When yes, for which reason? _____

2. Are you currently taking medication? ☐ yes ☐ no

When yes, which medication? _____

3. Do you suffer from any of the following diseases or disorders?

- | | | |
|--|--|---|
| ☐ Heart or cardiovascular disease | ☐ High blood pressure | ☐ Stroke (CVA) |
| ☐ Respiratory diseases | ☐ Glaucoma | ☐ Kidney disease |
| ☐ Rheumatic fever | ☐ Diabetes | ☐ Epilepsy |
| ☐ Osteoporosis | ☐ Other: _____ | |

4. Have you ever had a severe infection? ☐ yes ☐ no

☐ Hepatitis ☐ Tuberculosis ☐ HIV

5. Do you have allergies? ☐ yes ☐ no

When yes, which one(s)? _____

6. Do you experience prolonged bleeding after tooth removal or a cut wound? ☐ yes ☐ no

7. Do you take blood thinners (anticoagulants / antiplatelet agents)? ☐ yes ☐ no

8. Do you carry a medical alert card? ☐ yes ☐ no

9. Do you have a joint replacement? ☐ yes ☐ no

10. Have you suffered or are you suffering from a disease not listed above? ☐ yes ☐ no

When yes, which one(s)? _____

11. Have you ever had a medical emergency during a dental appointment? ☐ yes ☐ no

12. Have you smoked more than 200 cigarettes in your life? ☐ yes ☐ no

(When no, skip to question number 20)

13. At what age did you start to smoke? _____

14. Do you currently smoke cigarettes? ☐ yes ☐ no

(When yes, continue to question number 16)

15. In which year did you quit smoking? _____

16. Approximately how many cigarettes do you smoke daily? _____

17. Do or did you use other tobacco products on a regular basis?

- ☐ Cigar ☐ Pipe ☐ Hookah / water pipe ☐ E-cigarette / heated tobacco
☐ Chewing tobacco ☐ Other: _____

18. Have you ever tried to quit smoking? ☐ yes ☐ no

19. Are you presently considering quitting? ☐ yes ☐ no

20. Do you drink alcohol on a regular basis? ☐ yes ☐ no

21. Do you use other substances? ☐ yes ☐ no

22. Female patients: Are you pregnant? ☐ yes ☐ no

Name / address of your gynecologist: _____

Please inform your dentist of any changes in your medical status.

23. I agree to allow the clinic to use my medical information for research purposes. ☐ yes ☐ no

24. I am interested in participating in clinical research studies conducted by the clinic. ☐ yes ☐ no

I allow the information necessary for billing purposes to be submitted (when requested) to an insurance company, a collection or legal agency, as well as to the state authorities.

I am aware that, in accordance with the applicable legal provisions, every consultation, second opinion, diagnostic assessment, examination and treatment will be invoiced. The same applies to any costs for the provision of the working place, consumables, X-rays, dental technology, etc.

Should it be that during a treatment or the handling of instruments a clinic employee is contaminated with my blood (puncture, cut or splatter), I understand that I am obligated to allow blood to be drawn and examined for infectious diseases (hepatitis, HIV, etc.).

My physician is authorized to view my medical records.

Date: _____ Patient's signature: _____ Dentist's signature: _____

To be filled out by the clinic personnel:

17-14	13-23	24-27
47-44	43-33	34-37

☐ Student clinic ☐ Postgraduate dentist ☐ Private practice ☐ In-house dept. for: _____