



ZÜRI ZAHNI
CANO + ZIMMERMANN @ WRIGHT PLACE

General questionnaire

1. PATIENTS DATA

Name First name Date of birth
 Marital status single married widowed divorced Sex female male
 Nationality Profession Employer

The data of the guardian for children (under 18)

Name First name Date of birth
 Marital status single married widowed divorced Sex female male
 Nationality Profession Employer

The address

Street
 Zip code Residence Country

Phone

Privat Business Mobile
 Email

Additional informations

How did you become attentive of us?
 Previous dentist? Zip code
 Doctor? Zip code
 Health insurance/AHV-Nr.

2. METHOD OF PAYMENT

I am

Privat payer

I am supported by

- Social welfare office
- Asylum authorities
- EL-supplementary services

Other institutions (address and contactperson)

3. GENERAL HEALTH QUESTIONS

a) General questions

Reason for your visit?
 Are you feeling healthy at the moment? yes no
 Only for female patients: are you pregnant? yes, in the week no
 Have you recently been in a medical treatment? yes, why? no
 Are you affraid of the dental treatment? yes no
 Do you suffer from bad breath? yes no

b) Questions about your personal health

Have you ever had an extraordinary reaction to
 Nutrition yes no
 Medicine yes no
 Dental treatments yes no



- Do you have an allergy, possibly an allergy pass? yes no
- Have you ever had an extraordinary reaction at the dentist?
(e.g. dental materials, anesthesia/injections)? yes, which? no
- Do you take any medicine regularly? yes no
- If yes, which and why?
- Do you bleed long after injuries or do you take blood-thinning medication? yes no
- Are you in therapy for reduced bone density/osteoporosis? yes no
- Do you have an artificial joint? yes, where? no
- Do you need endocarditis prophylaxis and / or do you have an endocarditis pass? yes no
- Do you have a pacemaker, a stent and / or a heart card? yes no
- Are you immunocompromised or have you had an organ transplanted? yes no

Do you have or have you ever had any of these infectious diseases?

- Hepatitis A, B or C Jaundice / Icterus HIV+ / Aids
- Tuberculosis Rheumatic fever

Do you have or have you ever had any of the following illnesses?

- Heart disease, circulatory trouble Gastro-intestinal disease High blood pressure
- Diseases of the kidney or anomalies Heart attack disease of the thyroid gland
- Stroke Tumors, cancer Embolism / thrombosis
- Epilepsie Diabetes Osteoporosis
- Respiratory / lung disease Severe rheumatism Asthma
- Mental illness / depression

Any other sickness that isn't listed?

c) Questions about your life style

- Are you drinking alcohol regularly? yes no
- Are you smoking? yes, since years, approx. per day no
- Are you taking drugs? yes no
- If yes, which and how often?

I hereby release my treating dentist and the staff of the Züri Zahni dental surgery from medical confidentiality as follows:
 I grant permission to request medical files for inspection and to forward the necessary patient data to the respective private or government institutions for assessment, invoicing and / or forward debt collection. For the digital management of the medical history, a company specializing in dental software is allowed to save and secure patient data on a web-based basis.
 I also allow the attending dentist to discuss my case with other doctors and dentists in order to ensure optimal medical care.
 For laboratory work, I allow the dental practice, the responsible companies or dental technology laboratories to send the physical registrations, the virtual data sets and / or photos of my dental situation together with my personal data. The medical history and the personal data may be viewed by all employees of the dental practice - in compliance with medical confidentiality.
 I also undertake to regularly review my medical history and notify my dentist of any changes in my state of health.
 I accept the updated privacy policy and the guidelines for handling patient information.

Date Patient's signature

Legal representative

Updaten on Visa Updaten on Visa



Disclaimer Züri Zahni

Dear patient

We warmly welcome you to Züri Zahni and thank you in advance for the trust you have placed in us. An examination and / or possible therapy is planned for you. Before starting, we ask you to read the following information and to give us your consent with your signature.

At Züri Zahni we treat you according to the latest rules and findings of science. Despite high quality standards and careful work, complications or pain can arise.

THE FOLLOWING POINTS ARE TO BE OBSERVED

- Depending on the treatment, local elimination of the sensation of pain (local anesthesia) may be indicated. Despite professional use, general or local side effects are possible: intolerance to the substance used (allergy), reactions in the cardiovascular system (palpitations, drop / increase in blood pressure, dizziness) Bruising (bruises). In rare cases, conduction anesthesia can damage nerve fibers. As a result, a temporary facial asymmetry or temporary or very rarely permanent sensory disturbances (tingling, discomfort and even numbness) are possible in the corresponding supply area. Please refrain from eating as long as the anesthetic lasts, as this can lead to bite injuries, burns or frostbite.
- It may be necessary to shorten the length of a tooth or, depending on the degree of destruction, to pull it.
- Teeth, especially in the context of a root canal treatment or extraction, can break and may no longer be worth preserving.
- A root canal is an attempt to save the tooth (Success rate of over 90%). Long-term preservation is not guaranteed. Root canal instruments can rarely break or a complicated root canal anatomy makes an optimal therapy impossible.
- An extraction can cause pain, infection, swelling or bleeding. In very rare cases and with certain anatomical positions of the teeth, the maxillary sinus may open, nerve damage or a broken jaw.
- A reconstruction, be it a filling, a crown, a bridge, an implant or a prosthesis, can be damaged or loosen under heavy loads. The subsequent goodwill is based on the guidelines of the SSO.
- Appointments that are cancelled or rescheduled less than 24 hours in advance will be invoiced.

If you would like a cost estimate for your treatment, we ask you to inform us explicitly.

With your signature you confirm that you have taken note of the points listed above and that you have been informed in an understandable manner about the procedure and the risks of the examination or the procedure. Questions were answered to your satisfaction.

I agree to the treatment

Date

Patient's signature

Legal representative