

Oral health care

2023

PRELIMINARY INFORMATION FORM FOR ADULTS AND PEOPLE OVER 15 YEARS OVER IN DENTAL CARE

Dear client! Fill in this form when you arrive at the urgent dental care or if over 6 months have elapsed since your previous visit to the health centre's dental care.

Name:	Social security number:
Address:	Municipality of residence:
Telephone (during day):	Mobile phone:
Occupation:	Workplace:

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISEASES OR SYMPTOMS, OR HAD ANY OF THE PROCEDURES LISTED BELOW? (please tick the relevant boxes)

- increased risk of bleeding
 hypertension, result from the latest measurement: ____/____
 heart condition, please specify: _____
 artificial heart valve since: _____
 pacemaker since: _____
 blood vessel prosthesis since: _____
 artificial joint(s) since: _____
 radiation treatment in the head or neck area, year: _____
 diabetes
 rheumatic disease
 liver disease, please specify: _____
 kidney disease
 HIV/AIDS
 lung disease, asthma
 mental illness, nervous disorder
 epilepsy
 other general diseases, please specify: _____

I have not been diagnosed with any general diseases or symptoms mentioned below, not have I had any of the procedures

smoking
 snuff use

PREGNANCY

I am pregnant, due date: _____

ALLERGIES TO MEDICINES OR OTHER SUBSTANCES

- allergy to a medicine, please specify: _____
 other allergies, please specify: _____

ANAESTHESIA

- Have you been under anaesthesia before YES NO
 Were there any difficulties with the anaesthesia YES NO
 if YES, what? _____

CONTINUOUS MEDICATION

- osteoporosis medication since: _____
 Marevan or some other anticoagulant, please specify: _____ most recent INR level ____
 omega-3 supplements
 pain-relieving medication: _____
 anti-hypertensive medication: _____
 anti-arrhythmic or other cardiac medication: _____
 cholesterol medication: _____
 antidepressants: _____
 antirheumatics: _____
 anti-asthmatic or allergy medication: _____
 cortisone medication: _____
 cytostatics: _____
 other regular medication, please specify: _____

CONSENT TO THE DISCLOSURE OF DENTAL DATA IF NECESSARY

- I give permission to disclose my information when the treating health centre changes

SIGNATURE _____ / _____ 20 _____
Date

_____ signature