CENTER HOČEVAR
BIOLOGICAL
HEALTHCARE
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Medical Questionnaire

You are kindly asked to answer the following questions. You may send us your completed questionnaire via our email address before your first checkup. Your answers will be of great assistance to us in planning your course of treatment.

Thank you for your trust.

Gregor Hočevar, dr.dent.med.
M.Sc., University Master in Oral Implantology
Specialist in Biological Dentistry and Ceramic Implants
(ISMI Germany, IAOCI USA)

1. Purpose of your visit

Please state the reason you have come to us, such as: pain, dissatisfaction with the appearance of your teeth, to have silver fillings removed, determining possible inflammation fields, ceramic implants, problems with root canal treated teeth, gum problems, a second medical opinion, etc.

2. Acute Pain

Is pain present in your oral cavity or around your teeth? If so, where is it present, where is it localized, when does it occur and what triggers it?

3. Oral Procedures

Which procedures in your oral cavity or on your teeth have been carried out in the last three years?

4. X-Ray Diagnostics

Have you had an panoramic X-ray of all your teeth done in the last three months? If so, when?

5. Temporomandibular joint

Do you experience any pain or difficulties with your temporomandibular joint? Do you experience popping or pain when opening your mouth or biting? If so, on which side?

6. Chewing

Do you feel you can chew food thoroughly? Do you chew evenly or do you avoid a certain area due to pain or too few teeth?

General Medical History

7. Do you suffer from any illness? If so, which one(s)?

8. Have you undergone any medical treatment in the last two years? If so, for which illness?

9. Have you been hospitalized in the last two years? If so, what was the reason?

10. Which medication do you often or regularly take?

11. Do you take any food supplements (vitamins, minerals, etc.)? If so, which ones and how much?

12. Have you ever had any complications with local or general anesthesia? If so, when?

13.

14. Are you allergic to any medications or substances? If so, which ones?

15. Have you ever experienced any coagulation disorders? If so, when?

16. Have you ever been treated with cranial or cervical radiation? If so, when?

17. Do you currently have any contagious diseases? If so, which one(s)?

18. Have you ever received a blood transfusion? If so, when?

19. Do you smoke? If so, how many cigarettes per day?

20. How would you describe your current state? For example: healthy and full of energy or tired?

20. Please mark any illnesses or conditions which you have or have had:

- ☐ Diabetes
- ☐ Artificial heart valve
- ☐ Heart valve disease
- ☐ Anemia
- ☐ Stroke
- ☐ Viral hepatitis
- ☐ High blood pressure
- ☐ Sinus infection
- ☐ Digestive diseases
- ☐ Prostate disease
- ☐ Pace maker
- ☐ Malignant tumour (cancer)
- ☐ Thyroid diseases
- ☐ Multiple sclerosis (MS)
- ☐ Glaucoma
- ☐ Asthma
- ☐ Respiratory diseases
- ☐ Jaundice
- ☐ Heart Attack
- ☐ Migraines
- ☐ Liver disease
- ☐ Sexually transmitted diseases
- ☐ Persistent cough
- ☐ Enlarged lymph nodes
- ☐ Rheumatoid arthritis (joints)
- ☐ Leukemia
- ☐ Epilepsy
- ☐ Genetic heart defects
- ☐ High cholesterol
- ☐ Psychiatric treatment
- ☐ Kidney/liver disease
- ☐ Allergies
- ☐ Gynecological conditions

21. Do you have a condition not listed above? If so, which one?

22. Could you have been exposed to HIV/AIDS? If so, how?

23. Do you have HIV antibodies? If so, since when?

24. Women: are you pregnant? If so, when is your due date?

25. Are you vaccinated against corona virus (Covid-19)? If yes, how many times?

Would you like to add anything?

Please inform us if you are not interested in receiving electronic notifications of updates.

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Dear patient,

Thank you for choosing Center Hočevar for your dental treatment. We respect your time and other engagements, which is why you have chosen a specific time slot for your appointment. We have reserved this time slot for you and we kindly ask that you abide by it.

In case you cannot make your appointment for any reason, we kindly ask you to respect the **24-hour cancellation deadline**. You can cancel up to 24 hours before your appointment without any costs by calling +368 (0)8 200 53 58 or +386 (0)40 557 257, or by emailing us at info@centerhocevar.com. If you do not respect this deadline, we will charge you 150€ for the reserved time slot.

By signing this form, I confirm that I understand the terms and conditions of the cancellation deadline.

Signature:

Thank you for your understanding.

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DECLARATION OF CONSENT BY THE INDIVIDUAL

by the European Parliament and of the Council of 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (hereinafter referred to as the "General Regulation"), in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC

Name: _____
Surname: _____
Adress: _____
Email address: _____
Tel. No.: _____

By selecting this declaration, I give my consent to the controller of my personal data (the healthcare provider) to process my personal data (excluding health data, etc.), which it processes on the basis of the law and the contracts concluded and the performance of the healthcare activity, for the purpose of direct marketing, which includes the creation of tailor-made offers for me of different types of products in the field of the healthcare activity carried out by the healthcare provider, and invitations to events, based on an assessment and anticipation of my interests, economic situation, needs, etc., through:

- **Post,**
- **Emails,**
- **SMS and MMS messages,**
- **Telephone,**
- **Using automated dialling and communication systems to make calls to a subscriber's telephone number without human intervention**
-

I am aware that I may withdraw my consent, in whole or in part, at any time. I may do so by written declaration addressed to Reteče 205, 4220 Škofja Loka, or by e-mail to the following email address info@centerhocevar.com and the processing based on the withdrawn consent will cease on the day following receipt of the withdrawal of consent.

Date: _____ Signature:_____

Personal Information

Name:

Date and place of birth:

Gender: F M

Marital status:

Profession:

Home address:

Phone number:

E-mail:

By signing, I consent that the contents of this questionnaire may be used solely for medical purposes. Privacy is ensured.

Date: Signature: