



WELCOME TO OUR DENTAL PRACTICE

Before we can discuss your dental concerns together, we need some personal information from you. Medical information is particularly important for appropriate and low-risk treatment. If you have any questions or suggestions, please do not hesitate to contact us at any time. Of course, all your information is subject to medical secrecy.

PATIENTENDATEN

First name	<input type="text"/>	Name	<input type="text"/>
Street adr.	<input type="text"/>	Postcode, City	<input type="text"/>
Date of Birth	<input type="text"/> in <input type="text"/>	Phone	<input type="text"/>
E-Mail	<input type="text"/>	Profession	<input type="text"/>
health insurance	<input type="text"/>	Employer	<input type="text"/>

If you are not a health insurance member yourself, who is an insured member?

First name	<input type="text"/>	Name	<input type="text"/>
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How are you insured? statutory private voluntary with supplementary dental insurance

EXPLANATION

Please remind me of my next appointment by

Mail E-Mail Phone (multiple answers possible).

I will cancel appointments that I cannot keep at least 48 hours in advance, otherwise I will be charged for the costs of my absence.

Haar, _____ Signature _____



PATIENT

First name

Name

CARDIAC DISEASES

Cardiac insufficiency N J
Cardiac valve replacement N J
Cardiac anomaly N J
Cardiac arrhythmias N J
Angina pectoris (cardiac asthma) N J
Endocarditis N J
Cardiac infarction N J
when?

CIRCULATORY DISORDER

Blood pressure too high N J
Blood pressure too low N J
Do you experience difficulties with long-lasting haemorrhage? N J
Taking of anticoagulants? N J
If yes, specify (e.g. Marcumar, ASS, Plavix)

DISEASES OF THE NERVOUS SYSTEM

Epilepsy N J
Others

METABOLIC DISEASES

Diabetes N J
Gastric / intestinal disease N J
Thyroid disease N J
Kidney disease N J
Liver disease N J
Osteoporosis N J

Rheumatic disease N J

Have you ever had another serious disease? N J

Do you or did you receive treatment against one or several diseases? N J

If yes, please specify disease and time of treatment

ALLERGIES

Asthma N J
Hay fever N J
Sodium bicarbonate N J
Glycine N J
Penicilin N J
Latex N J
Other medications N J

Other substances N J

Do you have an allergy ID? N J
Hypersensitivity against

INFECTIOUS DISEASES

Liver inflammation/ jaundice (hepatitis A or B) N J
Tuberculosis N J
Chronic respiratory disease/ cough N J
HIV/Aids N J
Do you suffer from diseases of the immune system? N J
If yes, specify?

Are / were you dependent on alcohol / drugs? N J
Did you undergo surgery recently? N J
When and where?

Do / did you suffer from cancer? N J
If yes, what kind

Do / did you receive chemotherapy or radiation therapy? N J
If yes, when? _____

Do you smoke? N J
If yes, how many cigarettes do you smoke a day? _____

For our female patients:
Are you pregnant? N J
If yes, which week? _____