Eva-Marie Müller
ZAHNARZTPRAXIS

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 _____ Name _____

Street adr. _____ Postcode, City _____

Date of Birth _____ in _____ Phone _____

E-Mail _____ Profession _____

health insurance _____ Employer _____

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

First name _____ Name _____

How are you insured? ☐ statutory ☐ private ☐ voluntary ☐ with supplementary dental insurance

How satisfied are you with your smile? not satisfied 1 2 3 4 5 6 7 8 9 10 very satisfied

REQUEST FOR ADVICE

Professional dental cleaning N J
Bleaching N J
Dental aesthetic N J

Tooth-coloured ceramics N J
Orthodontic treatment N J
Others

_____

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 _____

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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? _____

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