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medical history sheet

General illnesses can also have an effect on dental treatment. In order to be able to treat you adequate and risk-free, I ask you to complete this questionnaire. It will be attached to your personal documents. All information is strictly confidential and subject to medical secrecy.

Last name	First name	Date of birth
Street/ Number	Post code & Place of residence	Phone (privat)
Occupation (optional indication)	Employer (optional indication)	Phone (occupational)/Mobile-No.
Health insurance	Email Address	

Only national Health patient: Voluntary insured? ☐ yes ☐ no supplementary dental insurance? ☐ yes ☐ no

Only private patient: Entitled to assistance? ☐ yes ☐ no

For persons not insured themselves (family members, children):

Last name of the member	First name	Date of birth

Desired treatment today: _____

I was referred / come on recommendation from: _____

For patients with statutory health insurance:

Please bring your health insurance card with you to the practice every time you visit.
Do you wish to be informed by us about the possibilities for optimal dental care, even if these services are not or only partially covered by health insurance? ☐ yes ☐ no

For all patients:
I would like more information about the following treatment options:

☐ Amalgam Remediation

☐ Cosmetic dentistry ☐ Tooth-coloured ceramic fillings ☐ Cast gold fillings

☐ Prophylaxis programme Would you like to be reminded of your next check-up every 6 months by our free and non-binding recall service ? ☐ yes ☐ no

In order to save you unnecessary waiting times and to be able to treat you calmly, our practice is run according to the ordering system. Therefore we ask you to keep your appointment punctually. **Reserved appointments that have not been released 24 hours in advance, will therefore be invoiced** (currently we charge 90,- € per half hour or part thereof). Please keep in mind, that patients who come to us with pain, will be included in the ordering system. We ask for your understanding that there may be delays in such cases.

I have taken note of the patient information according to Art. 13 DSGVO and hereby consent.

Date _____ Signature _____

Are you currently undergoing medical treatment? ☐ yes ☐ no

If yes, because of which disease? _____

Attending doctor / family doctor: _____

Regular medications? _____

Date of the last COVID-19 vaccination: _____

You are currently suffering or have suffered from any of the following conditions in the past?

Infectious diseases	Liver inflammation/yellitis (hepatitis A, B or C)	☐ yes ☐ no
	Tuberculosis	☐ yes ☐ no
	Chronic respiratory diseases	☐ yes ☐ no
	HIV / AIDS	☐ yes ☐ no
Heart diseases	Heart failure (insufficiency)	☐ yes ☐ no
	Irregular heartbeat (arrhythmia)	☐ yes ☐ no
	Heart attack, angina pectoris	☐ yes ☐ no
	Cardiac pacemaker, heart valve replacement	☐ yes ☐ no
Circulatory illnesses	high blood pressure (hypertension)	☐ yes ☐ no
	Low blood pressure (hypotension)	☐ yes ☐ no
	Dizziness, fainting spells	☐ yes ☐ no
	Anticoagulants ?	☐ yes ☐ no
Metabolic disorders	Diabetes	☐ yes ☐ no
	Gastrointestinal disorders	☐ yes ☐ no
	Diseases of the thyroid gland	☐ yes ☐ no
Diseases of the nervous system	Epilepsy	☐ yes ☐ no
	Cramps	☐ yes ☐ no
Blood disorders	Tendency to bleed (haemophilia)	☐ yes ☐ no
	Anaemia	☐ yes ☐ no
Allergies	Eczema, skin rash	☐ yes ☐ no
	Penicillin hypersensitivity	☐ yes ☐ no
	Asthma	☐ yes ☐ no
	Do you have an allergy pass?	☐ yes ☐ no

Artificial Joints? _____

Other diseases: _____

Did you already have a periodontitis treatment? If yes, when? _____	☐ yes ☐ no
Are you or were you smoker? If yes, number of cigarettes per day: _____	☐ yes ☐ no
Are you afraid of dental treatment?	☐ yes ☐ no
Are you or have you ever been addicted to drugs or alcohol?	☐ yes ☐ no
Are you or have you been under psychotherapeutic treatment?	☐ yes ☐ no
Did you have an operation recently?	☐ yes ☐ no
Have you been X-rayed in the mouth / jaw area last year?	☐ yes ☐ no
For women: Are you pregnant? If yes, which month? _____	☐ yes ☐ no

In your own interest, please inform us immediately of any changes to the above information!

Date _____ Signature _____