WELCOME TO OUR DENTAL PRACTICE

Pat.Nr:______

Prior to discussing discuss your dental concerns together, we would 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 of your information is subject to medical secrecy.

Personal Data

First name

Name

Street Adr.

Postcode, City

Date of Birth in

Phone

E-Mail

Profession

Health insurance

Employer

If you are do not have health insurance, please indicate who in your family is insured in Germany?

Mother Father

Name, Firstname

Date of Birth

statutory insured: compulsively insured Voluntarily with supplementary dental insurance

Privately insured Standard-Rate Basic-Rate Aid justified

In the event, that the patient has no existing health insurance in Germany, patient agrees to pay the invoice on the day of the dental treatment either in cash or trough EC-Card in the dental practice.

EXPLANATION

Please remind me of my next appointment by

Mail E-Mail Phone (multiple answers)

Munich, Date ______________ Signature X _________________

turn around->

HEALTH

Cardiac insufficiency N Y
Cardiac valve replacement N Y
Cardiac anomaly N Y
Cardiac aryhthmias N Y
Angina pectoris cardiac asthma N Y
Endocarditis Cardiac infarction N Y
When?

____

____

ALLERGIES

Asthma N Y
Hay fever N Y
Penicillin N Y
Latex N Y
Lactic acid N Y
Other medications: N Y
Which?

____

____

CARDIOVASCULAR DISEASE

High blood pressure N Y
Low blood pressure N Y
Tendency to bleeding / blood diseases N Y
Taking of anticoagulants? N Y
If yes, specify (e.g. Marcumar, ASS, Plavix) N Y

DISEASES OF THE NERVOUS SYSTEM

Epilepsy N Y
Other N Y
If yes, which? ____________________

____

MENTAL ILLNESS

Depressions N Y
Anxiety N Y
Other: _______________________ N Y
What medication are you taking?

____

INFECTIOUS DISEASE

Liver inflammation jaundice N Y
Hepatitis A or B N Y
Tuberculosis N Y
HIV/Aids N Y
Chronic respiratory diseases N Y
Do you suffer from diseases
of the Immune system? If yes, specify? N Y

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METABOLIC DISEASE

Diabetes N Y
Gastric intestinal disease N Y
Thyroid gland N Y
Kidney/ Livers disease N Y
Osteoporose N Y
Rheumatic disease N Y
Have you ever had any other serious
disease. Which?________________ N Y

____

Are/were you dependent on alcohol/drugs N Y
Do you have artificial joints? Knee/Hip N Y
Do you have plates or screws in your body? N Y
Did you undergo surgery recently? N Y
When and where? ___________

Do you suffer from cancer or did you suffer from cancer? If yes, where?______________________ N Y

Do/did you receive chemotherapy or radiation therapy? If yes, when?______________________________ N Y

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

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

Munich, Date_____________________________________

Signature X______________________