

Dear patient,

thank you for choosing our office for your dental care needs; we appreciate the opportunity to help you further. If you put emphasis on a professional and experienced team, as well as on a sound individual treatment concept, then you are right at home with us. Our team is proud to be your reliable partner and help you achieve your dental health goals. **If you can't keep scheduled appointments we ask you to give us a minimum of 24 hours notice if you need to make a change.**

What is the reason for your visit?

- Check Up (Kontrolle) Consultation (Beratung) Cleaning (Zst) Gum bleeding (Mu) TMJ issues (KG)
- Toothache (Zahnschmerzen) Problems with the dental work (crown, bridge) (ZE-Probleme) Others

Patient Male Female Child / Kindergarten School / Student

Last Name	First Name	Date of Birth
Street Name and House No.	ZIP Code	City
Phone No.	Mobile Phone	Email

Insurance Holder (For minor children usually one of the parents or the legal guardian) Male Female The same as the patient

Last Name	First Name	Date of Birth
Street Name and House No.	ZIP Code	City
Phone No.	Mobile Phone	Email

Medical Insurance Plan

Versichertenstatus

<input type="checkbox"/>	German public insurance (E.g. AOK, TK, BKK, DAK)
<input type="checkbox"/>	German private insurance
<input type="checkbox"/>	European Health Insurance Card (EHIC)
<input type="checkbox"/>	Student Insurance Plan
<input type="checkbox"/>	No insurance at all or other non european insurance plan

- Gesetzliche Krankenversicherung
- Private Versicherung
- EU Krankenversicherung
- Studenten Versicherung
- Ich bin nicht versichert oder habe eine non EU Versicherung

Dental Insurance Company	
Occupation	Employer

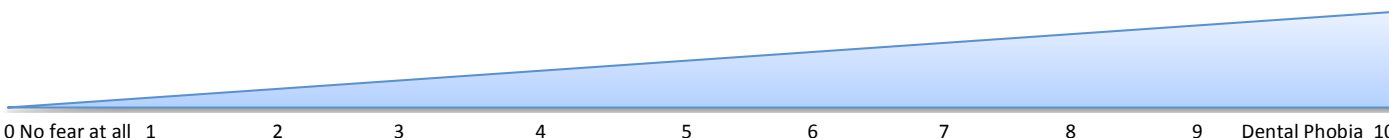
If you have a German public insurance plan you are obliged to show the insurance card at each visit to the doctor. If the card is not being shown within 10 days of treatment, we are entitled by law to bill you for the entire costs of the treatment.

How did you find our office (Refferal Source)?

Reffered by:

- Google Facebook Other Website Office sign Refferal

Are you afraid of the dental treatment? No Yes If yes, please check the intensity on the scale below



The purpose of the following questionnaire is to determine possible risks. Please answer conscientiously on behalf of your own safety. Your answers will be treated according to medical confidentiality and data protection laws. Should any points be unclear, please ask the doctor or the staff for help. Please also tell us future changes in your health status, address and state of insurance. *Thank you!*

		Yes	No
Heart/Circulatory System	Heart attack <i>If yes please tell us the year:</i>	<input type="checkbox"/>	<input type="checkbox"/>
	High blood pressure <i>If yes please tell us the average values</i>	<input type="checkbox"/>	<input type="checkbox"/>
	Infectious endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have a cardiac pace maker?	<input type="checkbox"/>	<input type="checkbox"/>
	Arrhythmias or fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
Blood coagulation	Anticoagulant therapy? <i>If yes please check below and tell us the last INR value</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Please check if you take one of the following medications:</i> <input type="checkbox"/> Marcumar <input type="checkbox"/> ASA <input type="checkbox"/> Aspirin <input type="checkbox"/> Iscover <input type="checkbox"/> Plavix <input type="checkbox"/> Eliquis <input type="checkbox"/> Pradaxa <input type="checkbox"/> Xarelto		
Hematologic Diseases	Hemophilia, Trombocytopenia, von Willebrand disease or similar	<input type="checkbox"/>	<input type="checkbox"/>
	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic Diseases	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	Hypothyroidism or Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
	Osteoporosys	<input type="checkbox"/>	<input type="checkbox"/>
	<i>If yes did you or do you take: Fosamax, Fosavance, Actonel, Bonviva, Zometa, Aclasta or similar?</i>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases	Hepatitis Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>
	Tuberculosis (TBC)	<input type="checkbox"/>	<input type="checkbox"/>
	AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System Diseases	Stroke <i>If yes, please tell us the year</i>	<input type="checkbox"/>	<input type="checkbox"/>
	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
	Mental illnesses, E.g.: depression, anxiety, phobia, general anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Intolerances	Drug or non-drug intolerance?	<input type="checkbox"/>	<input type="checkbox"/>
	Allergies? <i>If yes please list :</i>	<input type="checkbox"/>	<input type="checkbox"/>
Medication	Do you take medication on a regular basis? <i>If yes please list</i>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	Do you take or have taken drugs in the past?	<input type="checkbox"/>	<input type="checkbox"/>
For our female patients	Are you pregnant? <i>If yes, please tell us the month</i>	<input type="checkbox"/>	<input type="checkbox"/>

Other information that you consider important:

If you are under care of a physician: Name of the physician

City

Phone

	Yes	No
Would you like to have a professional dental cleaning? (PZR)	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in a consultation for dental work like crowns, bridges, implants, dentures (ZE-Beratung)	<input type="checkbox"/>	<input type="checkbox"/>
In case you need fillings should we use only tooth coloured fillings? Additional charges may apply (MKV)	<input type="checkbox"/>	<input type="checkbox"/>
Do you need a cosmetic dental treatment like veneers, bleaching, smile makeover? (Zahnverschönerung)?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to have a high quality tretment even though this would cost you more than regular treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to remind you for the next check up, usually within 6 months? (Recall)	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have read and fully understood the above and declare that the information provided by me in this questionnaire are true and complete. I take full responsibility for incidents or complications that may occur in the event that such information was false or incomplete. I hereby authorize the dental staff to perform necessary dental treatment mutually agreed upon by me as may be required for proper dental care.

Location/Date (dd/mm/yyyy)

Patient signature. For minor children signature of the parents or legal guardian