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PRAXISGEMEINSCHAFT
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Welcome in our dental surgery.

For quality treatment without any complications
we require the following information from you.
All details will be treated as confidential.
If you have any questions about this information sheet,
please feel free to ask, we will answer your questions
with pleasure.

PATIENT

____

Surname/ last name	first name	date of birth/ place of birth

MEMBER

____

Surname/ last name	first name	date of birth/ place of birth

ADRESS

____

Street, house number	postcode, place

TELEPHONE

____

Private	mobile	work

E-MAIL

____

JOB

____

Job	employers adress

INSURANCE

____

Insurance name

O compulsarily insured	O voluntary insurance
O compulsarily with an additional private insurance
O private insurance	O private insurance, allowance claim

Please note, that you are commilted to pay the entire bill, even if your insurance (private insurance or additonal private insurance) doesn`t always refund the complete amount.

Please fill in for treatment without any complications.

General Health questions.

Are you receiving any medical treatment at the moment? If so, why? O no O yes

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Have you been in hospital in the last 2 years? If so, why? O no O yes

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Do you take medicine regularly? If so, which medicine and why? O no O yes

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Are you allergic to any medicine or materials? (e.g. penicillin, Iodine etc.) O no O yes

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Do you have an allergy pass? O no O yes

Do you suffer from a heart desease? (e.g.cardia insufficiency, irregular heartbeat) O no O yes

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Blood pressure O high Do you take medication because of this? O no O yes
O low

Do you take medicine to stop the blood from clotting? (e.g. Marcumar, Aspirin)
or do you have any problems with blood clotting? O no O yes

Do you have a pacemaker? Have you suffered a heart attack? O no O yes

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Do you tend to faint? Do you take medicine with a soothing effect? (e.g. Valium) O no O yes

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Do you suffer from any of these following illnesses? O no

- O Diabetes
- O Asthma
- O Tuberculosis
- O Epilepsy
- O Rheumatism
- O Underactive/ overactive thyroid
- O stomach/ intestine problems
- O Kidney disease
- O HIV/ Aids

Have you had hepatitis A, B, C/ liver inflammation? O no O yes
If so, when?

Have you suffered any other illnesses? If so, which? O no O yes

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For woman: Are you pregnant? If so, which month? O no O yes

Please fill in for your dental treatment without any complications.

Dental questions.

Have you had any orthodontist treatment? O no O yes, have/had a brace

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Have you ever had gum-treatment? O no O yes, when?

Has there ever been any complcations at a dentist? O no O yes, which?

Have you ever had an accident where you hurt your mouth/face? O no O yes, when and

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Which changes can you observe on your teeth? O none

O gum bleeding
O loosening at the teeth
O sensitive reactions heat, sweets, or when chewing
O pain on the teeth
O surface deterioration from grinding
O distortion/ change of colour on filling or crowns

Do you suffer from Jaw/ face/ head or shoulder pains? O no O yes, where?

Have you had an x-ray done for your teeth or jaw in the last 12 month? O no O yes, where?

How did you find us?

O internet
O newspaper
O recommendation from a friend? Who?
____
O Yellow Pages
O street sign
O recommendation from a doctor?
____

A special and free service:
Do you want us to remind you regularly when your check up is due? O no O yes

Important information:
Our surgery is where patients are only seen with an appointment. This means that we reserve the time necessary for each treatment. This is why we ask you to cancel our appointment if you can`t make it **at least 48 hours before**hand! If not you might be charged for the missed time.
Thank you for your help.

Date/ Signature: ____