MEDICAL HISTORY DOCUMENT

Die Zahnarztpraxis
am Neuen Wall

Bevor we start talking about your dental concern,
we need some information about your general state
of health for your individual therapy.
All your specifications are definitely handled with professional discretion.

Name:

First name:

Date of birth: Place of birth:

Street number:

Post code, place:

Profession:

Mobile / cell:

E-mail:

Name of your health insurance company:

What is your medical history?

Please inform us of any change or modification of your state of health or address.

	Yes	No
Cardiovascular disease	☐	☐
Disruption blood clotting	☐	☐
Valvular heart defect	☐	☐
Endocarditis	☐	☐
Cardiac pacemaker	☐	☐
Rheumatism	☐	☐
Osteoporosis	☐	☐
Human immunodeficiency virus (HIV)	☐	☐
Hepatitis hepatitis	☐	☐
Liver disease	☐	☐
Glaucoma	☐	☐
Disease of tumor	☐	☐
Diabetes (type?)	☐	☐
Other deseases		

Please continue reading on the page 2

MEDICAL HISTORY DOCUMENT

Die Zahnarztpraxis
am Neuen Wall

page 2

	Yes	No	
Does the look of your teeth dissatisfy you?	☐	☐	
Are you currently in pain?	☐	☐	
Do you suffer from gum bleeding?	☐	☐	
Do you have problems chewing?	☐	☐	
Do you wish to have a counseling interview about:			
Your personal risk of tooth decay ?	☐	☐	
Peridontics?	☐	☐	
Esthetic dentistry ?	☐	☐	
Patient-centered implant care	☐	☐	
Alterntiv fillings	☐	☐	
Temporomandibular joint treatment	☐	☐	
	☐	☐	
Are you pregnant?	☐	☐	if: yes, week:
Do you smoke?	☐	☐	if: yes, how much
Do you have any allergies?	☐	☐	if: yes, what kind
Are you on medication?	☐	☐	if: yes, what kind

I am aware of the fact that I will receive a private invoice according to GOZ and GOÄ.
If I cannot make an appointment I will give notice at least 24 hours in advance.
Otherwise, I may have to cover the costs of 75 euros per hour.

Place, date signature

How did you hear about us?

☐ No, I do not wish to receive any important information about the practice via e-mail.

☐ No, I do not wish to receive a reminder prior to my appointment via text message.