

Dear patient!

We welcome you to our dental practice! Your health is important to us. Because general diseases can have effects on dental treatment, we ask you to fill out the questionnaire thoroughly and completely. Your personal data is subject to medical confidentiality and serves only to adapt your treatment ideally to your state of health. Please direct any enquiry to our reception.

Personal data

First name	Surname	Date of birth
Address		
Phone/mobile number	Email*	Profession/employer*
Insuree -	Name and address -	Date of birth

Insurance details

Please specify:

- | | |
|---|---|
| <input type="checkbox"/> Private health insurance
<input type="checkbox"/> Private health insurance with base rate
<input type="checkbox"/> Eligible for subsidy ("Beihilfe") | <input type="checkbox"/> Compulsory/national health service
<input type="checkbox"/> Voluntary insurance
<input type="checkbox"/> Cost reimbursement
<input type="checkbox"/> Supplementary private insurance
Which rate? _____ |
|---|---|

Insurance Company	Health fund/ Supplementary private insurance company
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How did you find us?*

- | | |
|---|---|
| <input type="checkbox"/> Google Search* / google adwords*
<input type="checkbox"/> Youtube*
<input type="checkbox"/> Facebook* / Instagarm*
<input type="checkbox"/> Jameda* | <input type="checkbox"/> Telephone book / Yellow Pages*
<input type="checkbox"/> Personal recommendation* _____
<input type="checkbox"/> Newspaper*
<input type="checkbox"/> Others* _____ |
|---|---|

Your primary concern for your visit? _____

Which services are you interested in?*

- | | | |
|--|------------------------------|-----------------------------|
| Would you like to be informed how to obtain your teeth healthy all your life?* | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Are you interested in high-quality tooth coloured amalgam alternatives?* | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Would you like to receive further information for a safe and compatible way to remove amalgam fillings?* | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Are you interested in modern, various options of bleaching your teeth?* | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Permanent tooth replacement (implants) is important to you?* | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Different services*: _____

Please turnaround →

Health record

To ensure a firm treatment and to avoid any complications an update of your state of health is required every second year. Do you /did you suffer of any of the following diseases? (Please check applicable)

- | | |
|---|--|
| <input type="checkbox"/> Allergy/incompatibilities _____ | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Lung diseases /respiratory ailment (e.g. Asthma) | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Bleeding disorder (Haemophilie) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hearth diseases (Insufficiency, Dysrhythmia etc.) | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Hearth attack, if so, when? _____ | <input type="checkbox"/> Rheumatic Diseases |
| <input type="checkbox"/> Are you wearing a pacemaker? | <input type="checkbox"/> Hemopathy oder Hemorrhage |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Psychosomatic diseases (E.g. depressions) |
| <input type="checkbox"/> High blood pressure ? <input type="checkbox"/> Low blood pressure? | <input type="checkbox"/> Are you taking any medicine currently or regularly? |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Marcumar <input type="checkbox"/> Heparin <input type="checkbox"/> ASS |
| <input type="checkbox"/> Faintings | <input type="checkbox"/> Antidepressiva |
| <input type="checkbox"/> Thyroid gland disease | <input type="checkbox"/> Bisphosphonats (e.g. by Osteoporosis) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pradaxa <input type="checkbox"/> Xarelto <input type="checkbox"/> Eliquis |
| <input type="checkbox"/> Carcinoma | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Are or have you been drug addicted? |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Are you pregnant? Which week?
_____ |
| | <input type="checkbox"/> Are you a smoker? |
| | <input type="checkbox"/> Amount/day* _____ |
| | <input type="checkbox"/> Others _____ |

General practitioner or specialist _____

* voluntary indication

General details

Please be advised that local anesthesia may impair your ability to drive a car and/or operate machines for up to 24 hours.

We will reserve a dedicated time slot for your appointment. In case of any cancellation, we do ask you to inform us 24 hours in advance. Otherwise a charge will be made.

Data protection

For the protection of your collected data, the processing is carried out in accordance with the guidelines in accordance with DSGVO Article 32.

You have the right to information, correction, revocation and deletion of your personal data at any time, provided that no legal or treatment-relevant aspects speak against it (DSVGO, Articles 15 to 17.)

Please also note the information about the data protection regulation (DSVGO) in the waiting room.

With your signature, you confirm that you have read and understood the complete form and the completeness and accuracy of your information on pages 1 and 2.

Sankt Augustin, _____
(date)

(Signature: patient or legal representative)