Patient history form

Dear patient!

We are glad that you entrust us your smile and your dental health.

It is our aim to provide you with the best possible individual treatment. Therefore, we would like to ask you to take a few minutes to read this questionnaire carefully and to fill it out as accurately as possible. We will talk about the most important questions and answers in detail with you in a moment. The information you provide with this questionnaire will only be used to optimize your treatment and will be kept confidential and not disclosed to any third party without your permission. Please inform us about any changes as it may negatively affect your treatment and may cause serious health issues.

1. Patient's personal information

☐ m ☐ f

Surname, Given names _____ Date of birth _____

Current address _____

Postal/Zip Code _____ City/Country _____

Phone _____ Mobile _____ E-mail _____

Insurance policy holder – If the patient is not the insurance policy holder

Surname, Given names _____ Date of birth _____

Current address _____

Postal/Zip Code _____ City/Country _____

Your health insurance?

☐ statutory health insurance ☐ voluntarily health insurance ☐ eligible for benefit
☐ private additional insurance ☐ private health insurance ☐ private insurance basic rate

Which insurance company? _____

2. General questions concerning your health

Were X-ray images of your teeth and/or head taken before? ☐ Yes ☐ No
When have they been made and who has done the X-ray images?

_____

Are you taking any medication on a regular basis? If yes, which medication? _____ ☐ Yes ☐ No

Do you have any allergic reactions? To materials? ☐ Yes ☐ No
To certain medicines? ☐ Yes ☐ No

Do you have any other hypersensitivity or allergery, in particular in regard to any medication? If yes, please specify.

_____

Do you or did you have a cardiac disease? If yes, which? ☐ Yes ☐ No
(e.g. heart attack, cardiac insufficiency, cardiac arrhythmias, heart valve defect, apoplectic stroke)

_____

Do you have a cardiac pacemaker? ☐ Yes ☐ No

Please note back of page →

3. Personal health check

Did or did you have one of the following diseases?

Infectious diseases (e.g. Hepatitis, HIV)?	☐ Yes	☐ No	Respiratory/Lung diseases (e.g. Asthma)?	☐ Yes	☐ No
Chronic liver diseases?	☐ Yes	☐ No	Blood disease / Coagulopathy?	☐ Yes	☐ No
High / low blood pressure?	☐ Yes	☐ No	Epileptic fits?	☐ Yes	☐ No
Gastric-infections / Intestinal illnesses?	☐ Yes	☐ No	Thyroid disorders?	☐ Yes	☐ No
Kidney diseases (e.g. dialysis)?	☐ Yes	☐ No	Tumor diseases?	☐ Yes	☐ No
Osteoporosis, Rheumatism?	☐ Yes	☐ No	Do you have any other diseases?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	If yes, please specify _____		

Have you always tolerated the injection at the dentist office? ☐ Yes ☐ No

Are you afraid of dental treatment? ☐ Yes ☐ No

Do you suffer from gum bleeding? ☐ Yes ☐ No

For our female patients: Are you pregnant? If yes, which month? _____ ☐ Yes ☐ No

Are you satisfied with your tooth position / tooth color? ☐ Yes ☐ No

4. How did you find out about us?

☐ Personal recommendation ☐ Jameda.de ☐ Kennstdueinen.de ☐ Google ☐ Facebook ☐ Homepage

☐ Print advertising ☐ Doctor's referral _____ ☐ Other _____

5. General agreement

The appointment system in our dental office is strictly organized in time slots for every single patient. That usually means only a few waiting times for you. In case you are unable to attend your appointment we would like to ask you to inform us **at least 24 hours before** in order to reschedule. Otherwise we would need to charge the costs caused by not attending the appointment (§§ 304,615 BGB). If you receive an short-termed emergency appointment in case of emergency, you must expect some waiting times.

For patients with statutory health insurance: In case you do not have your insurance card with you at your first appointment, we would like to ask you to submit it at least after 10 days. If your insurance card does not exist after this time period, we have to treat you as a private patient and you will receive an invoice.

I have filled out this questionnaire to the best of my knowledge and confirm with my signature that the provided information are complete and correct. Furthermore, I will inform you if there are any changes in the provided information.

Send form to practice **Print form**

_____ _____

Place, Date Signature of the patient / legal guardian