

Application form Medical history

Dear Patient,

Thank you for choosing our practice for dental treatment. It is managed using an ordering system. For you, this brings the advantage of reduced waiting times. However, medically necessary and not foreseeable treatment measures may lead to appointments not being exactly complied with in every case. We ask for your understanding. If you are not able to keep an appointment agreed with us, we kindly ask you to cancel it at the earliest possible time, that means, at least 24 hours in advance. If you come to our practice by reason of unforeseeable emergencies (e. g. acute pain), you will most likely have to wait for some time.

If you are insured under the statutory health insurance, it is absolutely necessary that you present your health insurance card to us no later than 10 days after treatment has been started, as otherwise the costs incurred by the treatment will have to be charged to your private account. If you are insured under the statutory health insurance, you can choose between a treatment under the statutory health insurance, using the health insurance card, and the treatment on private basis in accordance with Sec. 13 SGB V (reimbursement of costs).

Patient

Mr/Ms/Child

Surname		First name	Date of birth
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Address

Street/No.		E-Mail	
Postcode, town/city	Phone	Mobile	

**Insured person /
Person liable to pay**
(parent(s) for their children)

Surname		First name	Date of birth
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Anschrift

Street/No.		E-Mail	
Postcode, town/city	Phone	Mobile	

Name of payment body
(health insurance fund or insurance company)

Name of payment body		
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- | | | |
|---|--|---|
| <input type="checkbox"/> I am compulsorily insured | <input type="checkbox"/> I am privately insured | <input type="checkbox"/> I have chosen the reimbursement of costs in accordance with Sec. 13 SGB V |
| <input type="checkbox"/> I am voluntarily insured | <input type="checkbox"/> I am insured according to the standard rate | <input type="checkbox"/> I am not insured |
| <input type="checkbox"/> I am eligible for financial aid | <input type="checkbox"/> I am insured according to the base rate | <input type="checkbox"/> I am eligible for additional allowance (Sozialamt (Social Services Department), Versorgungsamt (Pension Office)) |
| <input type="checkbox"/> I have a supplementary private insurance | | |

Profession of the insured person

Profession of the insured person	
<input type="checkbox"/> Pupil/Student	Employer

Address of the employer

Street/No.	Postcode, town/city	Phone
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Profession of the patient

Profession of the patient	
<input type="checkbox"/> Pupil/Student	Employer

Address of the employer

Street/No.	Postcode, town/city	Phone
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01-12-15V

To complete your medical record, we need the following information, which are subject to the duty of medical confidentiality and to data protection, and which are treated by us as strictly confidential. Please keep our practice informed of any changes in your state of health, your address, and your insurance status in the future.

1. Do/did you have one of the following diseases?

a)		yes	no		yes	no		yes	no	
Asthma (severe shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>		Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>		Liver diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Blood coagulation disorders	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A/B/C (icterus)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		HIV infection	<input type="checkbox"/>	<input type="checkbox"/>		Seizure disorders (epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid diseases	<input type="checkbox"/>	<input type="checkbox"/>
Tumor/carcinoma/cancer	<input type="checkbox"/>	<input type="checkbox"/>		Do/did you take any bisphosphonates in this connection	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Your general practitioner:

Name	Address	Phone

b) Allergic reactions / intolerance of drugs or materials yes no If yes, which one(s)?

Do you have an allergy passport? yes no

c) Heart attack

Do you take Marcumar? yes no

Stroke yes no

Paralysis yes no

d) Blood pressure low normal high Values, if available

2. Do you have a cardiac pacemaker? yes no

3. Do you regularly take medicine? yes no If applicable, which one(s)?

4. Do you smoke? yes no

5. Are you pregnant? yes no uncertain If applicable, which week?

6. Do/did you have any injuries resulting from an accident in the area of mouth, jaw or face? yes no

Date of accident

Type of injury

7. Other information/other diseases

8. Do you attach special importance to a treatment under local anaesthesia? yes no

Please note that the fitness to drive can be impaired for several hours under the influence of drugs or injections for local anaesthesia.

9. Do you have an X-ray log? yes no

Do you wish to have an X-ray log? yes no

When did the last X-ray examination / computer tomography take place? (date/part of the body)

10. Do you have a "Bonusheft" (bonus book)? yes no I am interested in a prophylaxis programme, e. g. professional tooth cleaning. yes no

How/through whom did you first become aware of our dental practice:

By signing this form, I confirm that the details provided overleaf and above are complete and correct, and I expressly agree to the storage of my personal data.

Date	Signature of patient or parent
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