Medical history

Dear patient,

a warm welcome to our office. For a risk-free treatment, it is particularly important to answer the questions about your state of health carefully. All information is of course subject to the confidentiality of the dentist and his team. Thank you for your cooperation.

Patient

Surname: _____
First name: _____
Date of birth: _____
Place of birth: _____

Address: _____
_____

Telephone: _____
Mobile: _____
Email: _____

Job title: _____
Employer: _____

How did you hear about us?
_____

Are you the main insured? yes O no O

If not, who is the main insured?
Surname: _____
First name: _____
Date of birth: _____

Different billing address? no O

Surame: _____
First name: _____
Address: _____
_____

How are you covered by health insurance?

O Statutory at _____
Supplementary dental insurance?
O no O yes. Which one? _____

O Privat at _____
Standard or basic tariff? yes O no O
Eligible for aid? yes O no O

Do you exercise? yes O no O
If yes, what kind of exercise? _____
Do you smoke? yes O no O If yes, how many cigarettes per day? _____

What is the reason for your appointment today?

Dental checkup yes O no O
Do you have a toothache? yes O no O
Other reason: _____

Dental treatments:

Former dentist?_____
When was your last dental exam / treatment? _____
When were the last x-rays taken in your tooth / jaw area? _____
Have you already had professional teeth cleaning? O no O yes. When? _____
Do you do interdental care?
O Not yet O Dental floss O Interdental brush O other: _____

Please note the following two pages

Do you have gum problems? Does your gum bleed? yes O no O
Does your gum retreat? yes O no O
Are your teeth loosened? yes O no O
Have you noticed bad breath or suspect you have some? yes O no O
Do you have any noise in your jaw? yes O no O

Do you have any pain in your jaw? yes O no O
Do you have a bite tray? yes O no O

Do you or your partner snore? yes O no O
Do you suffer from daytime sleepiness? yes O no O
Is your partner watching your breathing misfires? yes O no O

Are you satisfied with your tooth color? yes O no O
Are you satisfied with your tooth position? yes O no O
Would you like advice on a specific topic? _____ yes O no O

Are there any health risks?

If yes, which? _____
_____

Do you suffer from an allergy? yes O no O
If yes, which? _____
Do you have a stomach or bowel disease? _____ yes O no O
Do you have a cardiovascular disease? _____ yes O no O
Do you have bleeding disorders? _____ yes O no O
Do you have high blood pressure? Low blood pressure? yes O no O
Do you have diabetes? yes O no O
Do you have an eye disease (e.g. glaucoma)? _____ yes O no O
Do you have a kidney disease? _____ yes O no O
Do you have a thyroid disorder? yes O no O
Do you have or have you had cancer?_____ yes O no O
Do you suffer from an infectious disease? yes O no O
HIV O Hepatitis B O Hepatitis C O

Do you take any medicine? yes O no O
If yes, which? _____
_____

Do you suffer from migraines? yes O no O
Are you pregnant? If yes, in which week? _____ yes O no O

Would you like an appointment reminder by SMS? yes O no O

I am aware that as a legally insured person I am obliged to present my insurance card within 10 days. Otherwise, the services rendered will be billed in accordance with the GOZ. With my signature I confirm the accuracy of the information.

Hamburg, den _____ _____

Short-term cancellation of an appointment and agreement on a default fee