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andreagleim
zahnärztin

WELCOME!

Before we talk to you about your dental needs , we need not only your personal details also information about your general health . This is important for a low-risk treatment . All information subject to medical confidentiality .

PATIENT DATA

Name of the patient:
born on:
Address:
Name of the health insurance:

Please specify when **statutory health insurance**:

compulorily insured	yes		no	
voluntarily insured	yes		no	
Do you have an additional private insurance?	yes		no	
Do you have selected a reimbursement?	yes		no	

Please indicate when **private insurance**:

Standard fare?	yes		no	
Are you student-insured?	yes		no	
Are you eligible for the aid?	yes		no	

Phone:
Fax:
Mobile:
Office:
Email:
Occupation:
Employer:

INSURED DATA (unless they differ from the patient data)

Invoice to the patient or to the insured ?

Insured:
born on:
Address:

MORE INFORMATION

How would you like to be reminded of your appointments ? ☐ by phone ☐ by letter ☐ by email

Appointments that I can not comply , I will cancel 24 hours in advance , otherwise the costs incurred by my absence can be billed .

YOUR PERSONAL HEALTH CHECK

	yes	no
heart disease	☐	☐
Pacemaker / artificial heart valves	☐	☐
high blood pressure	☐	☐
low blood pressure	☐	☐
fainting tendency	☐	☐
Warfarin / anticoagulant	☐	☐
Bleeding / blood disease	☐	☐
rheumatism	☐	☐
diabetes	☐	☐
thyroid disease	☐	☐
Liver disease (hepatitis)	☐	☐
Stomach / intestinal disease	☐	☐
kidney disease	☐	☐
Pulmonary disease / asthma	☐	☐
Nasal / sinus disease	☐	☐
Epilepsy	☐	☐

Do you have any other serious diseases (e.g. HIV infection , other autoimmune diseases) ? yes ☐ no ☐

If yes , which? ____________________

What medications you take regularly ?

____

____

____

Do you respond sensitive to certain medications ? yes ☐ no ☐

If yes , which? ____________________

Are you a Smoker? yes ☐ no ☐

If yes , how many cigarettes a day ? ____________________

	yes	no
Take the „pill“ ?	☐	☐
Get a hormone therapy ?	☐	☐
Get a bisphosphonate in tumor or osteoporosis disease ?	☐	☐
Are you pregnant?	☐	☐

If yes , in what month? ____________________

PURPOSE OF YOUR VISIT

check-up	yes		no	
toothache	yes		no	
bleeding gums / Halitosis	yes		no	
Migraine / headache / neck pain	yes		no	
TMJ / crunch	yes		no	
Do you only want pain treatment ?	yes		no	

Others ?

YOU ARE IMPORTANT TO US

What should we consider most in your treatment ?

Fear of dental surgery	yes		no	
Strong pain sensitivity	yes		no	
strong gag reflex	yes		no	

What did you miss most in your visit to the dentist ?

Who recommended us ?

CONSULTING DESIRE

Professional tooth cleaning	yes		no	
Are you satisfied with your tooth color ?	yes		no	
Dental Aesthetics / Beauty / your smile	yes		no	
Tooth-colored ceramic fillings	yes		no	
Orthodontic Treatment	yes		no	
Amalgam / mercury outside line	yes		no	
Cervical restorations	yes		no	
hypnosis treatment	yes		no	
Implants/Implants supply	yes		no	

Others ?

We need your health insurance card at each visit in practice . If we did not get to 14 days after treatment , we consider you a private patient and you will receive an invoice .

I hereby express my consent for electronic data transmission , for example, Transmission of x-rays .

Date

Signature