



PRAXIS FÜR ZAHNHEILKUNDE  
DAGMAR KUROSZCZYK  
DR. MED. DENT. ANKE LOTT  
ZAHNÄRZTE

Adults

Dear Patient,

Before we take time to talk to you in person about your individual dental wishes and requirements, we also need, in addition to your personal details, information about your general state of health (medical history). The answers to all our questions are treated in the strictest confidence and the information is used solely for the purposes of your dental treatment in our surgery.

Family name \_\_\_\_\_ First name \_\_\_\_\_ Date of birth \_\_\_\_\_

Postcode \_\_\_\_\_ Town/city \_\_\_\_\_

Street/house no. \_\_\_\_\_ Telephone no. \_\_\_\_\_

Mobile phone no. \_\_\_\_\_ Fax no. \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Health insurance \_\_\_\_\_

Statutory health insurance  Supplementary insurance

Private health insurance  Benefit allowance

If you yourself are not the health insurance policy holder, please state whose insurance you are covered under.

Family name \_\_\_\_\_ First name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

**Do you suffer from any of the following dental problems?**

- |  |  |   |
|--|--|---|
| <input type="radio"/> Over-sensitive teeth           | <input type="radio"/> Teeth grinding         | <input type="radio"/> Dental pain                 |
| <input type="radio"/> Pain in or clicking of the jaw | <input type="radio"/> Halitosis (bad breath) | <input type="radio"/> Discolouration of the teeth |
| <input type="radio"/> Bleeding gums                  | <input type="radio"/> Loose teeth            | <input type="radio"/> Other? _____                |

**Are currently taking any medication?**  no  yes

If so, please specify \_\_\_\_\_

Are currently receiving medical treatment?  no  yes

General practitioner / specialist \_\_\_\_\_

**Do you suffer from any allergies?**  no  yes

If so, please specify \_\_\_\_\_

**Heart and circulatory disorders**

Cardiac insufficiency (weak heart)  no  yes Irregular pulse  no  yes

Cardiac valve replacement/heart defect  no  yes High blood pressure  no  yes

Cardiac asthma, angina  no  yes Low blood pressure  no  yes

Pacemaker  no  yes How high? \_\_\_\_\_ / \_\_\_\_\_

Myocardial infarction (heart attack)  no  yes

Other? \_\_\_\_\_

**Lung disorders**

Asthma  no  yes Other? \_\_\_\_\_

**Liver and metabolic disorders**

Liver disease  no  yes thyroid disorder  no  yes

Diabetes  no  yes Other? \_\_\_\_\_

**Infectious diseases**

Inflammation of the liver (hepatitis A / B / C)  no  yes  
Have you had an HIV test?  no  yes

Tuberculosis  no  yes  
If so, please state the results. \_\_\_\_\_

**Blood disorder**

Bleeding diathesis (haemophilia)  no  yes  
Other? \_\_\_\_\_

Anaemia  no  yes

**Disorder of the nervous system**

Epilepsy  no  yes  
Psychosomatic disorders  no  yes

Cramps / convulsions  no  yes  
Other? \_\_\_\_\_

**Gastro-intestinal disorders**

no  yes

**Kidney disorders**  no  yes

**Tumours / tumour surgery**

Bisphosphonate therapy  no  yes

**Pregnancy**  
If so, what stage? \_\_\_\_\_

**Drugs**

Drug consumption  no  yes  
Do you smoke?  no  yes

Alcohol consumption  no  yes

**Eating disorders**

Bulimia  no  yes

**X-ray examinations**

Has an x-ray been taken of your head-jaw-dental area within the last 12 months?  no  yes

**Your individual wishes are important to us ...**

Personal expectations / concerns regarding your impending dental treatment \_\_\_\_\_  
\_\_\_\_\_

Reason for your dental appointment today? \_\_\_\_\_

What is of particular importance to you? \_\_\_\_\_

What, in your opinion, were the shortcomings during previous visits to the dentist? \_\_\_\_\_  
\_\_\_\_\_

Are you scared of dental treatment?  no  yes

Would you like to receive a check-up reminder every 6 months?  no  yes

If so, in what way?  by mail  by telephone  by e-mail  by text message

I am interested in receiving advice on the following:

- Professional dental cleaning  Dental replacement  Dental implantology  Individual prophylaxis programme
- Periodontosis  Dental aesthetics  Dental irregularity correction  Cavity risk assessment
- Removal of amalgam fillings  Dental bleaching  Oral hygiene products
- Interest in other areas? \_\_\_\_\_

How did you find out about us?

Internet  Recommended by \_\_\_\_\_  Other source \_\_\_\_\_

Have you visited our surgery website at [www.zahnpoint-weisenau.de](http://www.zahnpoint-weisenau.de)?  no  yes

Date \_\_\_\_\_ Signature \_\_\_\_\_

We hope that you feel comfortable in our surgery, and we are happy to answer any questions you may have.