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?

○ Over-sensitive teeth ○ Teeth grinding ○ Dental pain
○ Pain in or clicking of the jaw ○ Halitosis (bad breath) ○ Discolouration of the teeth
○ Bleeding gums ○ Loose teeth ○ 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
Tuberculosis ◯ no ◯ yes
Have you had an HIV test? ◯ no ◯ yes
If so, please state the results. _____

Blood disorder

Bleeding diathesis (haemophilia) ◯ no ◯ yes
Anaemia ◯ no ◯ yes
Other? _____

Disorder of the nervous system

Epilepsy ◯ no ◯ yes
Cramps / convulsions ◯ no ◯ yes
Psychosomatic disorders ◯ 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
Alcohol consumption ◯ no ◯ yes
Do you smoke? ◯ 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? ◯ no ◯ yes

Date _____ Signature _____

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

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