

Dear Patient – A warm welcome to our Dental Office!

We try hard to make your stay with us as comfortable as possible. Short waiting periods are a result of our efforts. We therefore ask you to cancel agreed appointments 24 h in advance. However, patients without an appointment, e.g. patients suffering from pain, will have to accept longer waiting periods. As a member of a German public health insurance, please provide your health insurance card 10 days after first treatment at latest, since we otherwise have to bill you directly. As a member of a commercial / private health insurance, we will invoice you directly for the treatment.

In order to best suite your individual needs, please complete the following questionnaire:

Patient:

Mr./ Mrs./Ms. /Dr./ Child Last Name First Name Date of birth (Day/Month/Year)

Address Street, No.

Post / zip code City

Tel. no. private Day time tel. no. e-Mail

Member/ Invoice addressee:

Mr./ Mrs./Ms./Dr. Last Name First Name

Address Street, No.

Post / zip code City

Tel. no. home Tel. no during the day e-Mail

Name of health insurance Insurance: private compulsory voluntary government

Occupation Employer

Employer's address Street, No. Tel. no.

Post / zip code City

GENERAL HEALTH RECORD

1. Do you/ did you suffer of any of the following diseases?

(Please check where applicable)

- | | |
|---|--|
| <input type="checkbox"/> Heart attack (date) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke (date) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Paralysis (date) | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Blood pressure <input type="checkbox"/> low <input type="checkbox"/> normal <input type="checkbox"/> high
(value) | <input type="checkbox"/> Bleeding disorder
(which)..... |
| <input type="checkbox"/> Allergic reaction to medication:
(which) | <input type="checkbox"/> HIV-Infection |
| <input type="checkbox"/> Allergies(e.g. hay fever)
(which) | <input type="checkbox"/> Hepatitis (when)..... |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> TBC |
| | <input type="checkbox"/> Thyroid malfunction |

2. Are you wearing a **pacemaker** no yes
3. Are you **pregnant** no yes week
4. Date of last **X – ray** approx.
5. Are you taking **medications** no yes which :
6. **Bleeding gums** no yes

DENTAL HEALTH RECORD

1. Are you content with your smile and the color of your teeth yes no
(We are happy to inform you about various options of bleaching)
2. Are you interested in tooth colored **Amalgam-Alternatives** yes no
3. Are you interested in further information on one of the following methods on treatment in modern dentistry:
- Prophylaxis** - healthy teeth for ever
 - 'smile-make over'** - esthetic dentistry
 - Implants** - permanent tooth replacement

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any changes in my health or change in medication, I will inform the dentist at the next appointment.

Date, Signature