Application I from Medical history

Dear Patient,

Thank you for choosing our practice for dental treatment. It is managed using an ordering system. For you, this brings the advantage of reduced waiting times. However, medically necessary and not foreseeable treatment measures may lead to appointments not being exactly complied with in every case. We ask for your understanding. If you are not able to keep an appointment agreed with us, we kindly ask you to cancel it at the earliest possible time, that means, at least 24 hours in advance. If you come to our practice by reason of unforeseeable emergencies (e. g. acute pain), you will most likely have to wait for some time.

If you are insured under the statutory health insurance, it is absolutely necessary that you present your health insurance card to us no later than 10 days after treatment has been started, as otherwise the costs incurred by the treatment will have to be charged to your private account. As a patient with statutory health insurance, you can also arrange with your health insurance fund to have treatments carried out on a private in-voice in accordance with § 13 SGB V (reim-bursement of costs), as an alternative to treat-ments covered by statutory health insurance, using your health insurance card. Further infor-mation on this can be obtained from your health insurance fund.

Patient
Mr/Ms/Child

Surname | First name | Date of birth

Address

Street/No. | E-Mail* | Place of birth

Postcode, town/city | Telephone or mobile

Occupation of patient

Employer

☐ Pupil/Student

Address of the employer*

Street/No. | Postcode, town/city | Phone

Legal representative or alternative invoice recipi-ent, where appli-cable (parent(s) for their children)

Surname | First name | Date of birth

Address

Street/No. | E-Mail*

Postcode, town/city | Telephone or mobile

Occupation of legal representati-ve or alternative invoice recipient*

Employer

☐ Pupil/Student

Address of the employer*

Street/No. | Postcode, town/city | Phone

Name of payer
(health insurance fund or insurance company)

☐ I am compulsorily insured
☐ I am voluntarily insured
☐ I am eligible for financial aid
☐ I have a supplementary private insurance
☐ I am privately insured
☐ I am insured according to the standard rate
☐ I am insured according to the base rate
☐ I have chosen the reimbursement of costs in accordance with Sec. 13 SGB V
☐ I am not insured
☐ I am eligible for additional allowance (Sozialamt (Social Services Department], Versorgungsamt [Pension Office]

* optional details

Please note reverse side.

To complete your medical record, we need the following information, which are subject to the duty of medical confidentiality and to data protection, and which are treated by us as strictly confidential. Please keep our practice informed of any changes in your state of health, your address, and your insurance status in the future.

Please tick as appropriate for each question.

1. Do/did you have one of the following diseases?

a)

	yes	no		yes	no		yes	no
Asthma (severe shortness of breath)	☐	☐	Blood disorders	☐	☐	Hepatitis A/B/C (icterus)	☐	☐
Diabetes	☐	☐	Blood coagulation disorders	☐	☐	Seizure disorders (epilepsy)	☐	☐
Rheumatism	☐	☐	Heart defect	☐	☐	Thyroid diseases	☐	☐
Osteoporosis	☐	☐	Endocarditis	☐	☐	Renal impairment	☐	☐
Tuberculosis	☐	☐	MRSA hospital germ	☐	☐	Creutzfeldt-Jakob	☐	☐
HIV infection	☐	☐	Liver diseases	☐	☐	Tumor/carcinoma/cancer	☐	☐

Other information/other diseases

Your general practitioner:

Name | Address | Phone

Previous dental practice*

Name | Address | Phone

b) Do you have any existing allergies? ☐ yes ☐ no If yes, which one(s)?

Do you have an allergy passport? ☐ yes ☐ no

c) Heart attack ☐ yes ☐ no

Stroke ☐ yes ☐ no

Paralyzes ☐ yes ☐ no

Do you take any blood thinners? ☐ yes ☐ no If yes, which one(s)?

d) Do you have high blood pressure? ☐ yes ☐ no Do you have low blood pressure? ☐ yes ☐ no

2. Do you have a cardiac pacemaker? ☐ yes ☐ no

Do you have an artificial heart valve? ☐ yes ☐ no

3. Are you taking bisphosphonates? ☐ yes ☐ no

Are you taking immunosuppressants? ☐ yes ☐ no

Do you regularly take medicine? ☐ yes ☐ no If yes, which one(s)?

4. Do you smoke? ☐ yes ☐ no If so, how many cigarettes per day?

5. Do you snore? ☐ yes ☐ no

6. Do you have any addictions? ☐ yes ☐ no If yes, which one(s)?

7. Are you pregnant? ☐ yes ☐ no ☐ uncertain If applicable, which week?

8. Do/did you have any injuries resulting from an accident in the area of mouth, jaw or face? ☐ yes ☐ no

Date of accident

Type of injury

9. Does a care dependency within the meaning of Sec. 15 SGB V (German Social Security Code, Book V) exist? ☐ yes ☐ no If yes, to which degree?

10. Is integration assistance within the meaning of Sec. 99 SGB IX (German Social Security Code, Book IX) being provided? ☐ yes ☐ no If yes, which one(s)?

11. Do you attach special importance to a treatment under local anaesthesia? ☐ yes ☐ no

Please note that the fitness to drive can be impaired for several hours under the influence of drugs or injections for local anaesthesia.

12. Do you have an X-ray log? ☐ yes ☐ no

When did the last X-ray examination / computer tomography take place? (date/part of the body)

13. Do you have a „Bonusheft" (bonus book)? ☐ yes ☐ no

When did your last professional tooth cleaning take place?

14. Do you use the electronic patient record? ☐ yes ☐ no

How/through whom did you first become aware of our dental practice:*

With my signature I confirm the completeness and correctness of the above information.

Date | Signature of patient or parent