ZAHNARZTPRAXIS
MARIA GÜTTLER | GARCHING

anamnesis

Dear Patient,

We are very pleased to welcome you in our dental practice. Before we can devote your dental wishes, we require besides your personal data, also information about your general health. This is important for an adequate and low-risk treatment. We will talk about the most important questions and answers in detail with you in a moment. As a matter of course all information are subject to the medical confidentiality. We would be pleased to help you if you have any questions.

1 | Personal information

PATIENT'S CONTACT DETAILS

☐ m ☐ f

Surname, Given Name | Date of birth | Place of birth

Street | ZIP Code / City

Phone No. | Mobile

E-Mail

Profession | Phone No. Employer

Employer/Company

If you are not the insurance policy holder please provide further details:

INSURANCE POLICYHOLDER

☐ m ☐ f

Surname, Given Name | Date of birth

Street | ZIP Code / City

Phone No. | Mobile

E-Mail

Profession | Phone No. Employer

Employer / Company

INSURANCE

Health Insurance Company

☐ Legally Insured ☐ Private Health Insurance

2 | General questions concerning your health

Name of the family doctor

Contact data

Were X-ray images of your teeth and/or head taken before? ☐ Yes ☐ No

When have they been made and who has done the X-ray images?

MEDICAL TREATMENT

Are you under medical treatment at the moment? ☐ Yes ☐ No
If yes due to which illness?

HEART COMPLAINT

Cardiac insufficiency? ☐ Yes ☐ No

Cardiac pacemaker/ Artificial heart valve? ☐ Yes ☐ No

State after a heart attack? ☐ Yes ☐ No

Other

VASCULAR DISEASES

High blood pressure? ☐ Yes ☐ No

Low blood pressure? ☐ Yes ☐ No

Other

INFECTIOUS DISEASES

Hepatitis (A/B/C)? ☐ Yes ☐ No

Tuberculosis? ☐ Yes ☐ No

HIV? ☐ Yes ☐ No

METABOLIC DISEASES

Diabetes? ☐ Yes ☐ No

Thyroid disorders? ☐ Yes ☐ No

Kidney diseases? ☐ Yes ☐ No

Gastric-infections / Intestinal illnesses? ☐ Yes ☐ No

Chronic liver disease? ☐ Yes ☐ No

Other?

DISORDERS OF THE NERVOUS SYSTEM

Epileptic fits? ☐ Yes ☐ No

Depressions? ☐ Yes ☐ No

OTHER DISEASES AND INFORMATION

Rheumatism? ☐ Yes ☐ No

Lung diseases /Asthma? ☐ Yes ☐ No

Nasal diseases / Paranasal sinuses deseases? ☐ Yes ☐ No

Do you have any other diseases? ☐ Yes ☐ No

If yes, please specify

3 | Specific questions concerning your health

MEDICATION

Are you regularly taking any medication? ☐ Yes ☐ No
If yes, which medication?

Are you taking any blood-thinning medication? ☐ Yes ☐ No
If yes, which medication

ALLERGY

Do you have any hypersensitivity or allergy, in particular in regard to any medication? ☐ Yes ☐ No
If yes, please specify.

Do you have an allergy pass? ☐ Yes ☐ No

Are you taking any medication against osteoporosis or tumour diseases (for example bisphosphonates)? If yes, which medication? ☐ Yes ☐ No

Do you consume alcohol or other drugs on regular basis? If yes, please specify. ☐ Yes ☐ No

FOR OUR FEMALE PATIENTS

Do you breastfeed? ☐ Yes ☐ No

Are you pregnant? If yes, which month? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you consume stimulants or sedatives? If yes, please specify. ☐ Yes ☐ No

DO YOU WANT TO BE REMINDED OF YOUR NEXT APPOINTMENT?

☐ Yes ☐ No

☐ via phone call ☐ via postage ☐ via E-Mail

HOW DID YOU FIND OUT ABOUT US?

☐ Recommendation from _____ ☐ Internet ☐ Telephone book ☐ Other _____

Appointments

In order to avoid latency, your appointments are scheduled exclusively for you. In case you are unable to attend your appointment we would like to ask you to inform us **at least 24 hours before** in order to reschedule. Otherwise we would need to charge the costs caused by not attending the appointment.

Participating in traffic

Be aware that the dental treatment or the received medication might affect your ability to drive a car for up to 24 hours. This may be caused both by the treatment itself, as well as by the influence of injections, or other medicaments. On request, we gladly call you therefore a taxi that brings you home safely.

Health Insurance Card

We require your health insurance card at every visit to our dental practice. If it is not present 14 days after your treatment, we consider you as a private patient and you will receive an invoice.

Declaration

I have filled out this questionnaire to the best of my knowledge and confirm with my signature that the provided information are complete and correct. Furthermore, I will inform you if there are any changes in the provided information.

Place, Date

Signature of patient

Print

Send via email