ANAMNESIS

DENTIQUA
Dentale Qualität für Ihre Zähne

Welcome to our practice

Before we talk to you about your dental needs, we need information about you as a patient and your health status. This is important for an adequate treatment with little risks. All information is subject to the medical confidentiality.

Patient Information

Name of patient _____

Date of birth _____

Address _____

_____

Name of health insurance _____

If you are insured by public health insurance please indicate

Do you have an additional private insurance? Yes ○ No ○

Please specify when a private insurance is present

Student insurance Yes ○ No ○

Entitled to aid Yes ○ No ○

Telephone _____

Fax _____

Mobile Phone _____

Telephone office _____

E-mail address _____

Occupation _____

Data of insured Person (if it differs from the patient information)

Name of insured person _____

Date of birth _____

Address _____

_____

Additional Information

How would you like to be reminded of your next check-up appointment? telephone ○ e-mail ○ post ○

Please cancel appointments that you cannot perceive at least 24 hours in advance. Otherwise accruing costs might be invoiced, according to § 615 BGB (German Civil Code).

_____

Date, Signature

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Your personal health check

Patient _____

Tick and fill in as appropriate

Heart disease	Yes ○ No ○
Pacemaker / artificial heart valves	Yes ○ No ○
High blood pressure	Yes ○ No ○
Low blood pressure	Yes ○ No ○
Fainting tendency	Yes ○ No ○
Marcumar / anticoagulant	Yes ○ No ○
Bleeding tendency / blood diseases	Yes ○ No ○
Rheumatism	Yes ○ No ○
Diabetes	Yes ○ No ○
Thyroid disease	Yes ○ No ○
Liver disease	Yes ○ No ○
Stomach / intestinal diseases	Yes ○ No ○
Kidney disease	Yes ○ No ○
Lung disease / Asthma	Yes ○ No ○
Nasal / Sinus disease	Yes ○ No ○
Epilepsy	Yes ○ No ○
Do you suffer from infectious diseases? (Hepatitis / AIDS / TBC)	Yes ○ No ○
Did you suffer from injuries or surgery on your head If so, where?	Yes ○ No ○ _____
Do you have other serious diseases? If so, which ones?	Yes ○ No ○ _____
Allergies Which ones?	Yes ○ No ○ _____
What medication do you take regularly?	_____ _____
Do you react sensitively to some medications? If so, to which ones?	Yes ○ No ○ _____
Do you smoke? If so, how many cigarettes do you smoke a day?	Yes ○ No ○ _____

For our female patients

Are you pregnant?	Yes ○ No ○
If so, which week?	_____

_____

Date, Signature