MVZ Dentologicum und
ZMVZ Dentologicum 275 in üBAG GbR

DENTOLOGICUM

DENTOLOGICUM 275

MEDICAL HISTORY

Dear patient!

We are pleased to welcome you to our practice. To make you feel as comfortable as possible during your visit we need your help. We kindly request you to complete the below medical history as accurately as possible so that we can fulfil your wishes to our best possible. Even common diseases can impact your dental treatment. All information is subject to medical professional confidentiality.

PERSONAL DETAILS

Surname, First name | City of birth | Date of birth

Address (Street, No.) | ZIP, City

Phone (landline) | Phone (work) | Phone (mobile)

Email address | Profession, Employer

Reminder Service ☐ SMS ☐ Email

INSURANCE DETAILS

Health Insurance

☐ Statutory Health Insurance (SHI) (Gesetzlich versichert)
☐ Private Insurance (Privat versichert)
☐ Additional Insurance (Zusatzversicherung)
☐ Basic fare (Basistarif)
☐ Eligible for Government Allowance (Beihilfeberechtigt)
☐ Voluntary Insurance (Freiwillig versichert)

If patient and insurant are not identical please fill in the data of the insurant.

Surname, First name | Date of birth

Address (Street, No.) | ZIP, City

GENERAL HEALTH CONDITION

	yes	no
High blood pressure	☐	☐
Low blood pressure	☐	☐
Blood clotting disorder	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐
Diabetes	☐	☐
Heart diseases if yes, which:	☐	☐
Thyroid disorder	☐	☐
Glaucoma	☐	☐
Rheumatoid diseases	☐	☐
Chemotherapy or radiation	☐	☐
Recurring psychotherapeutic/ psychiatric therapy	☐	☐
Allergies if yes, which:	☐	☐
Allergy pass card	☐	☐

Other diseases:

	yes	no
HIV	☐	☐
Hepatitis	☐	☐
Tuberculosis	☐	☐

Other:

	yes	no
Are you regularly taking medicine? if yes, which:	☐	☐

☐ Meds for heart conditions:

☐ Cortisone:

☐ Painkiller:

☐ Antidepressants:

☐ Blood thinners:
(e.g. ASA, Marcumar, Heparin)

☐ Bisphosphonates/
meds for osteoporosis:

☐ Others:

	yes	no
Do you smoke?	☐	☐
Do you consume drugs or mind-altering drugs regularly or from time to time?	☐	☐

To our female patients:

	yes	no
Are you pregnant? if yes, which week of pregnancy:	☐	☐

>>> PLEASE TURN AROUND>>>

ORAL HEALTH CONDITION

Is there an specific concern that leads you to our practice?

- ☐ Preventive check-up
- ☐ Cosultation
- ☐ Pain therapy
- ☐ New dental prosthesis
- ☐ Referral from the dentist
- ☐ Second opinion
- ☐ Other: .....

	yes	no
Are you content with the position and form of your teeth?	☐	☐
Are you grinding your teeth or pressing?	☐	☐
Do you have issues with your gum? Bleeding while brushing your teeth? Receding gums?	☐	☐
Are you suffering from bad breath or a bad taste in your mouth?	☐	☐
Were your teeth cleaned professionally before, and on a regular basis (half-yearly/anually)?	☐	☐
May we offer you the service to remind you of preventive care on a half-yearly/annual basis?	☐	☐

Do you have any other questions or specific concerns?

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How did you learn about our practice?

- ☐ Personal recommendation
- ☐ Walking by
- ☐ Advertisement: .....
- ☐ Referral by general practitioner: .....
- ☐ Internet: .....
- ☐ Other: .....

Since we are offering appointments only, time during your appointment is reserved only for you.
We therefore kindly request to cancel any appointment in time, the latest 24 hours in advance.
This will give us the chance to offer the appointments other patients.
Long waiting times are hence usually avoided.

Please confirm the accuracy of your information with your signature.

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City, date Signature