MVZ Dentologicum und ZMVZ Dentologicum 275 in üBAG GbR

MEDICAL HISTORY

Dear patient!

We are pleased to welcome you to our clinic. 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 hat 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 /for a certificate of incapacity to work

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)

REASONS FOR VISITING OUR CLINIC

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

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:

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	yes	no
HIV	☐	☐
Hepatitis	☐	☐

Other:

.....

Are you on any medication? if yes, which:	☐	☐

☐ Meds for heart conditions:

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☐ Cortisone:

.....

☐ Painkiller:

.....

☐ Antidepressants:

.....

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

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☐ Bisphosphonates/
meds for osteoporosis:

.....

☐ Others:

.....

Do you smoke?	☐	☐
Do you consume mind-altering drugs regularly or from time to time?	☐	☐

To our female patients:

Are you pregnant? if yes, which week of pregnancy:	☐	☐

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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