mundum
ZAHNARZTPRAXIS

Dear patient,
welcome to our office!

PATIENT INFORMATION

Patient's name: _____

_____

Date of birth: _____

Birthplace: _____

Address: _____

_____

Phone number: _____

Fax: _____

Mobile: _____

Work phone: _____

E-mail address: _____

Occupation: _____

Insurance company: _____

Are you publicly insured (statutory insurance)?

yes ☐ no ☐

Are you privately insured?

yes ☐ no ☐

Do you have supplementary dental insurance?

yes ☐ no ☐

REASON FOR YOUR VISIT

Check-up	yes ☐	no ☐
Toothache	yes ☐	no ☐
Bleeding gums	yes ☐	no ☐
Migraine / headache / neckache	yes ☐	no ☐
Jaw pain	yes ☐	no ☐
Teeth grinding	yes ☐	no ☐
Mouth odor	yes ☐	no ☐
Are you interested in being treated for pain?	yes ☐	no ☐

Other _____

INSURANCE AND BILLING

(If different from patient information)

Should the patient or insurance company receive the invoice? _____

Person insured: _____

Date of birth: _____

Address: _____

FAMILY DOCTOR

Name: _____

Address: _____

_____

Phone: _____

ADDITIONAL INFORMATION

Are you interested in regular preventive care to reduce the risk of further health issues? ☐ yes ☐ no

How would you like to be reminded about your appointments for preventative care? ☐ by mail ☐ by e-mail

YOU'RE IMPORTANT TO US

Is there anything particular we should take into consideration during your treatment?

_____

_____

_____

Do you have a fear of dental procedures?	yes ☐	no ☐
Sensitive teeth?	yes ☐	no ☐
Severe gag reflex?	yes ☐	no ☐

Is there anything you found was missing during your previous dental appointments?

_____

_____

_____

HEALTH-RELATED QUESTIONS

In the next section, we kindly request you to tell us more about your overall health and about any medications you may be taking regularly. This allows us to arrive at the most precise diagnosis and to suggest the most appropriate treatment.

Please check all illnesses and conditions from which you currently suffer or have overcome in the past.

HEART yes ☐ no ☐

- ☐ Heart attack When: _____
- ☐ Angina pectoris
- ☐ Congenital heart defect
- ☐ Cardiac insufficiency, heart failure
- ☐ Shortness of breath on exertion
- ☐ Cardiomyopathy, heart muscle disease
- ☐ Cardiac arrhythmias
- ☐ Endocarditis, heart valve disease
- ☐ Heart valve replacement
- ☐ Pacemaker / implantable cardioverter defibrillator
- ☐ Endocarditis prophylaxis
- ☐ _____

RESPIRATORY SYSTEM yes ☐ no ☐

- ☐ Pneumonia
- ☐ Asthma
- ☐ Dry cough
- ☐ Tuberculosis
- ☐ Chronic bronchitis
- ☐ Sleep apnea
- ☐ _____

KIDNEYS yes ☐ no ☐

- ☐ Kidney inflammation
- ☐ Kidney insufficiency
- ☐ Dialysis: on the following days
  - ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri
- ☐ _____

METABOLISM yes ☐ no ☐

- ☐ Diabetes mellitus
  - Insulin-dependent
  - Oral medication
  - Diet
- ☐ Thyroid hyperfunction
- ☐ Thyroid hypofunction
- ☐ _____

CIRCULATORY SYSTEM yes ☐ no ☐

- ☐ High blood pressure value: _____ mmHg
- ☐ Low blood pressure
- ☐ Fainting spells

BLOOD VESSELS yes ☐ no ☐

- ☐ Stroke When: _____
- ☐ Varicose veins, blood clots
- ☐ Embolism
- ☐ Blood flow disorder
- ☐ _____

ALLERGIES yes ☐ no ☐

against:

- ☐ Medication / antibiotics
- ☐ Latex
- ☐ Metals
- ☐ Pollen
- ☐ _____
- ☐ I have my allergy pass with me
- ☐ Intolerances

_____

LIVER yes ☐ no ☐

- ☐ Jaundice / hepatitis
  - ☐ A ☐ B ☐ C ☐ _____
- ☐ Fatty liver
- ☐ Liver cirrhosis

BLOOD yes ☐ no ☐

- ☐ Coagulation disorder
- ☐ Severe bruising, nose bleeds
- ☐ Postoperative hemorrhage
- ☐ Blood-thinning medications
- ☐ Leukemia
- ☐ Anemia
- ☐ _____

NERVES AND MENTAL HEALTH yes ☐ no ☐

- ☐ Seizures, epilepsy
- ☐ Paralysis
- ☐ Mental disability
- ☐ Parkinson's disease
- ☐ Depression
- ☐ Dementia
- ☐ Anxiety
- ☐ Stress
- ☐ _____

SKELETAL SYSTEM yes ☐ no ☐

- ☐ Joint disease
- ☐ Rheumatic disease
- ☐ Artificial joint
- ☐ Muscle disorder
- ☐ Physical disability
- ☐ Osteoporosis
- ☐ _____

VISION yes ☐ no ☐

- ☐ Visually impaired
- ☐ Glaucoma
- ☐ _____

OTHER DISEASES AND CONDITIONS yes ☐ no ☐

- ☐ Tumor / cancer
- ☐ Transplant
- ☐ Angioedema
- ☐ _____

SUBSTANCES

CIGARETTES yes ☐ no ☐

How many per day? _____

ALCOHOL yes ☐ no ☐

- ☐ Occasionally
- ☐ Large amounts regularly

OTHER yes ☐ no ☐

Please indicate _____

DIGESTIVE SYSTEM yes ☐ no ☐

- ☐ Gastric ulcer
- ☐ Acid reflux
- ☐ Digestion dysfunction
- ☐ Crohn's disease
- ☐ Eating disorder
- ☐ _____

INFECTIONS yes ☐ no ☐

- ☐ HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ _____

MEDICATIONS TAKEN REGULARLY yes ☐ no ☐

(Please indicate ALL medications you are taking on a regular basis or provide us with a list from your general practitioner)

- ☐ Blood pressure medication
- ☐ Heart medication

  Anticoagulants:
  - ☐ Aspirin®, ASS®
  - ☐ Plavix®, Brilique®
  - ☐ Marcumar®, Warfarin®, Falithrom®
  - ☐ Pradaxa®, Xarelto®, Eliquis®
  - ☐ _____
- ☐ Painkillers
- ☐ Birth control pills
- ☐ Psychotropic drugs
- ☐ Bisphosphate
- ☐ Respiratory agents

Indicate which medications:

_____

_____

_____

_____

PREGNANCY yes ☐ no ☐

WOULD YOU LIKE TO DISCUSS SOMETHING SPECIFIC DURING YOUR APPOINTMENT?

Routine dental cleaning
yes ☐ no ☐

Whitening / Bleaching
yes ☐ no ☐

Cosmetic medical treatment
yes ☐ no ☐

Pain-minimizing laser treatment
yes ☐ no ☐

Tooth-colored ceramic fillings
yes ☐ no ☐

Displaced tooth treatment
yes ☐ no ☐

Nutrition-related questions
yes ☐ no ☐

Dental implants
yes ☐ no ☐

Saliva test
yes ☐ no ☐

Gum disease treatment
yes ☐ no ☐

Jaw correction (Bite splint)
yes ☐ no ☐

You'll need to bring your insurance card to every visit. If you do not present your card, you will be regarded and billed as a privately insured patient. Should you not be able to observe your scheduled appointment, please cancel at least 24 hours in advance. You will otherwise be billed for the cost of the missed appointment.

All of the information you provide is safely protected under medical confidentiality and will be treated as strictly confidential.

Please let us know if your health changes over time!

I hereby declare that the information I provided above is correct and complete.

Signature _____ Date _____ Place _____

NEXT APPOINTMENT

Please select

Signature _____ Date _____ ☐ no changes ☐ changes

Signature _____ Date _____ ☐ no changes ☐ changes

Signature _____ Date _____ ☐ no changes ☐ changes

Signature _____ Date _____ ☐ no changes ☐ changes

Signature _____ Date _____ ☐ no changes ☐ changes