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ZAHNÄRZTE

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Welcome to our office

We are pleased that you entrust your dental health to us.
Before your treatment, we not only need your personal details we also need some information about your general health. This is important for a risk-free treatment. All the information from you are subject to medicial confidentiality. Please advise us of any changes without delay.
Thank you.

Last Name of the Patient	First Name	Date of birth Patient
Street , House Number	ZIP Code, City	Sponsors Name
Private Phone Number	Work Phone Number (Voluntary Information)	Social Security Sponsor
Email	Insurance Company/Tricare Dental	

Do you take any Medication at the moment? If yes, which?_____

Do you take an blood thinner? If yes, which?_____

Take a drug or other narcotics? _____

Have you took any bisphosphonates medications the last 15 years? ☐ Yes ☐ No

Allergies:_____

Do you have or ever had the following diseases?

☐ Heart disease _____	☐ Liver disease _____	
☐ Kidney disease _____	☐ Nerve disease _____	
☐ High blood pressure	☐ Low blood pressure	☐ Stroke
☐ Asthma / Lung disease	☐ Diabetes	☐ Rheumatism
☐ Bleeding disorder	☐ Pacemaker	☐ Epilepsy
☐ Hyperthyroidism	☐ Hypothyroidism	☐ Tuberculosis
☐ Immunodeficiency (HIV)	☐ Hepatitis	☐ AIDS

Other:_____

The reason for your Dentist visit:

☐ Routine examination	☐ Toothache	☐ Malocclusion
☐ TMJ Problems	☐ Teeth grinding	☐ Tooth mobility
☐ Bleeding gums	☐ New Dentures	☐ Problems with dentures
☐ Professional tooth cleaning (PTC)		
☐ Other: _____		

For female Patients: Are you pregnant? ☐ Yes ☐ No If yes month**+ due date** _____/_____

Are you breastfeeding at this moment? ☐ Yes ☐ No

How did you hear about our dental office? _____

Our special service - we would like to remind you on all of your appointments. How?
That´s your choice. (separate written consent must be given)

6 month check up: ☐ Text Message ☐ E-Mail ☐ not at all

Your treatment appointment: ☐ Text Message ☐ not at all

I was informed that in a case of a local anesthetic my ability to drive is restricted. I commit myself to immediately notify any changes that occur throughout the treatment. I further agree to abide by deadlines or at least 24 hours notice to cancel. Not timely canceled appointments may be charged.

Date _____ **Signature** _____