

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 medical 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
_____	_____	_____
Phone Number / Mobile Phone	Work Phone Number (Voluntary Information)	Social Security Sponsor
_____	_____	_____
Email	Insurance Company/Tricare Dental	Unit/ Rank

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

Do you take a blood thinner?                              If yes, which? \_\_\_\_\_

Take a drug or other narcotics?                              If yes, which? \_\_\_\_\_

Do you take a denosumab? (Medication to osteoporosis(cancer therapy)                               Yes    No

Have you taken any bisphosphonates medications the last 15 years? (Medication to osteoporosis/cancer therapy)  Yes    No

Allergies: \_\_\_\_\_

Do you have or ever had the following diseases?

- Heart disease, if yes, which kind: \_\_\_\_\_
- Liver disease, if yes, which kind: \_\_\_\_\_
- Kidney disease, if yes, which kind: \_\_\_\_\_
- Nerve disease, if yes, which kind: \_\_\_\_\_
- High blood pressure                               Low blood pressure                               Stroke
- Asthma / Lung disease                               Diabetes                               Rheumatism

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Bleeding disorder      | <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Epilepsy     |
| <input type="checkbox"/> Hyperthyroidism        | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Immunodeficiency (HIV) | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> AIDS         |

Other: \_\_\_\_\_

The reason for your Dentist visit:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Routine examination               | <input type="checkbox"/> Toothache      | <input type="checkbox"/> Malocclusion           |
| <input type="checkbox"/> TMJ Problems                      | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Tooth mobility         |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> New Dentures   | <input type="checkbox"/> Problems with dentures |
| <input type="checkbox"/> Professional tooth cleaning (PTC) |   |   |
| <input type="checkbox"/> 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?  Recommendation from family / friends
- Community
  - Facebook
  - Google
  - Other \_\_\_\_\_

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.

I was advised that the Dental Office BAG Dr. Markus Schmid / Dr. Johannes Ermer works together with the Orthodontic Office Dr. Heike Schmid but each office is legally independent. The data process of the two offices takes place in one program.

I have been advised and agree that the respective practice owners and practitioners may exchange all necessary medical and other personal data relating information about myself.

Weiden, \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature from patient / and or legal guardian