

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: _____

Prosthetic joints: _____

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: _____

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma / Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatism |

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|---|---|---------------------------------------|
| <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
- | |
|--------------------------------------|
| <input type="checkbox"/> Community |
| <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Google |
| <input type="checkbox"/> 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