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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
_____	_____	_____
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? _____

Do you take a drug or other narcotics? If yes, which? _____

Do you consume THC / cannabis regularly? □ Yes □ No

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

Do you agree to use fluoride for your children's treatment □ Yes □ No □ no children

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: _____

□ 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? □ Recommendation from family / friends

□ Community

□ Facebook

□ Google

□ DTV Daniel Television

□ 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