

# Application I from Medical history

## Dear Patient,

Thank you for choosing our practice for dental treatment. It is managed using an ordering system. For you, this brings the advantage of reduced waiting times. However, medically necessary and not foreseeable treatment measures may lead to appointments not being exactly complied with in every case. We ask for your understanding. If you are not able to keep an appointment agreed with us, we kindly ask you to cancel it at the earliest possible time, that means, at least 24 hours in advance. If you come to our practice by reason of unforeseeable emergencies (e. g. acute pain), you will most likely have to wait for some time.

If you are insured under the statutory health insurance, it is absolutely necessary that you present your health insurance card to us no later than 10 days after treatment has been started, as otherwise the costs incurred by the treatment will have to be charged to your private account. If you are insured under the statutory health insurance, you can choose between a treatment under the statutory health insurance, using the health insurance card, and the treatment on private basis in accordance with Sec. 13 SGB V (reimbursement of costs).

### Patient

Mr/Ms/Child

Surname		First name	Date of birth
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Address

Street/No.	E-Mail*	Place of birth*
Postcode, town/city	Telephone or mobile	

### Insured person / Person liable to pay

(parent(s) for their children)

Surname		First name	Date of birth
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Address

Street/No.	E-Mail*
Postcode, town/city	Telephone or mobile

### Name of payment body

(health insurance fund or insurance company)

Name of payment body		
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- |   |  |   |
|---|--|---|
| <input type="checkbox"/> I am compulsorily insured                | <input type="checkbox"/> I am privately insured                      | <input type="checkbox"/> I have chosen the reimbursement of costs in accordance with Sec. 13 SGB V  |
| <input type="checkbox"/> I am voluntarily insured                 | <input type="checkbox"/> I am insured according to the standard rate | <input type="checkbox"/> I am not insured   |
| <input type="checkbox"/> I am eligible for financial aid          | <input type="checkbox"/> I am insured according to the base rate     | <input type="checkbox"/> I am eligible for additional allowance (Sozialamt (Social Services Department), Versorgungsamt [Pension Office]) |
| <input type="checkbox"/> I have a supplementary private insurance |  |   |

Profession of the insured person\*

Profession of the insured person*	
Employer	

Pupil/Student

Address of the employer\*

Street/No.	Postcode, town/city	Phone
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Profession of the patient

Profession of the patient	
Employer	

Pupil/Student

Address of the employer

Street/No.	Postcode, town/city	Phone
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\* optional details

Please note reverse side.

To complete your medical record, we need the following information, which are subject to the duty of medical confidentiality and to data protection, and which are treated by us as strictly confidential. Please keep our practice informed of any changes in your state of health, your address, and your insurance status in the future.

Please tick as appropriate for each question.

1. Do/did you have one of the following diseases?

a)	yes	no		yes	no		yes	no
Asthma (severe shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood coagulation disorders	<input type="checkbox"/>	<input type="checkbox"/>	Renal impairment	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	MRSA hospital germ	<input type="checkbox"/>	<input type="checkbox"/>	Creutzfeldt-Jakob	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Liver diseases	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/carcinoma/cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C (icterus)	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you take any	<input type="checkbox"/>	<input type="checkbox"/>
HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders (epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	bisphosphonates in this		
						connection		

Your general practitioner:

<input type="text"/>	<input type="text"/>
Name	Address
<input type="text"/>	
Phone	

b) Do you have any existing allergies?  yes  no If yes, which one(s)?

Do you have an allergy passport?  yes  no

c) Heart attack  yes  no

Stroke  yes  no

Paralyzes  yes  no

Do you take any blood thinners?  yes  no If yes, which one(s)?

d) Blood pressure  low

normal

high Values, if available

2. Do you have a cardiac pacemaker?  yes  no

3. Do you regularly take medicine?  yes  no If yes, which one(s)?

4. Do you smoke?  yes  no | 5. Do you snore?  yes  no

6. Do you have any addictions?  yes  no If yes, which one(s)?

7. Are you pregnant?  yes  no  uncertain If applicable, which week?

8. Do/did you have any injuries resulting from an accident in the area of mouth, jaw or face?  yes  no

Date of accident

Type of injury

9. Other information/other diseases

10. When was your last hospital stay?

11. Does a care dependency within the meaning of Sec. 15 SGB V (German Social Security Code, Book V) exist?  yes  no If yes, to which degree?

12. Do you attach special importance to a treatment under local anaesthesia?  yes  no **Please note that the fitness to drive can be impaired for several hours under the influence of drugs or injections for local anaesthesia.**

13. Do you have an X-ray log?  yes  no

Do you wish to have an X-ray log?  yes  no

When did the last X-ray examination / computer tomography take place? (date/part of the body)

14. Do you have a „Bonusheft“ (bonus book)?  yes  no

When did your last professional tooth cleaning take place?

How/through whom did you first become aware of our dental practice:\*

With my signature I confirm the completeness and correctness of the above information.

<input type="text"/>	<input type="text"/>
Date	Signature of patient or parent