

MEDICAL HISTORY QUESTIONNAIRE

Dear patients, welcome to our office. To assist us in providing you with the best possible treatment and standard of care we ask you to complete this medical history questionnaire. Any information provided will be treated in strict confidence and available only to third parties you have consented to.

This practice is run on an appointment system. In order to minimize waiting periods, we organize appointments as accurately as possible. Nevertheless, if there are patients with dental emergencies, your appointment could be delayed. If you receive an appointment on short notice, some waiting time is to be expected. Should you be unable to keep your appointment, please let us know at least 24 hours in advance, or as soon as possible, otherwise a cancellation fee might be elicited.

Personal information

Last name (patient), first name

Date of birth

Street, house number

Postal code, city

Home telephone

Mobile phone number

Email

Occupation of patient

Employer

Health insurance member/ Who should the bill be addressed to?

Last name, first name

Date of birth

Street, house number

Postal code, city

Home phone number

Mobile phone

Email

Job title of member

Employer

Krankenversicherung

Health insurance company or private insurance

I am compulsory insured

Privately insured

Voluntarily insured

I have additional private insurance

I have basic rate insurance

I have standard rate insurance

I have chosen the reimbursement according to § 13 SGB V.

I am eligible for funding

I have no insurance

Who is your personal physician?

Name, address, phone number

