ÄSTHETISCHE ZAHNMEDIZIN
am Gänsemarkt

MEDICAL HISTORY QUESTIONNAIRE

ZAHNARZTPRAXIS M. TALEH & TEAM

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

General medical history

1. a) Have you ever had the following:

Asthma/ lung conditions yes ☐ no ☐ Blood disorders yes ◯ no ◯ Liver disease yes ☐ no ☐

Blood coagulation disorder yes ◯ no ◯ Diabetes yes ◯ no ◯ Hepatitis yes ◯ no ◯

Thyroid disease yes ◯ no ◯ Fainting attacks, blackouts, epilepsy? yes ◯ no ◯ Are you HIV-positive? yes ◯ no ◯

Osteoporosis yes ◯ no ◯ Rheumatic fever yes ◯ no ◯ Tuberculosis yes ◯ no ◯

Any form of cancer yes ◯ no ◯ Do you or did you take bisphosphonates? yes ◯ no ◯

1.b) Allergic reactions / Intolerances

To any drugs or medications yes ◯ no ◯ If yes, please list:

Do you have an allergy ID card? yes ☐ no ☐ If yes, please list:

1.c) Heart attack

Do you take any general anti-clotting drugs? yes ☐ no ☐ If yes, please list:

Stroke yes ☐ no ☐

1.d) Blood pressure low ☐ normal ☐ high ☐ If necessary, levels:

2. Do you wear a pacemaker? yes ☐ no ☐

3. Any current medications? yes ◯ no ◯ If yes, please list

4. Do you smoke? yes ◯ no ◯

5. Are you pregnant? yes ◯ no ◯ uncertain ◯ When due

6. Are you gnashing or pressing your teeth? yes ◯ no ◯

7. Do you have bleeding gums? yes ◯ no ◯

8. Do you suffer from bad breath or a bad taste in your mouth? yes ☐ no ☐

9. Are you happy with the appearance, color and shape of your teeth? yes ☐ no ☐

10. Any other health concerns/ other conditions

11. Do you have an x-ray registration card? yes ☐ no ☐ Would you like do have one? yes ☐ no ☐

When was your last x-ray exam/ computed tomography? (date/body part)

12. Would you like a recall? yes ☐ no ☐

13. Are you interested in our professional dental hygiene programme? yes ☐ no ☐

14. How did you hear about us?

15. Do you have any other questions?

By signing this form I confirm that the above is true and accurate and agree to the filing of my data in my patient record.

Date Signature

Submit Form

Print form