PATIENT DATA SHEET

zahnarztpraxis steinberg
ZAHNÄRZTE IN DER KAISERPASSAGE

Dear Patient,

Before we talk about your dental needs, we need information on your person as well as information about your general health. After all, general illnesses can have an effect on the dental treatment. Therefore, we ask you to complete this paper. Of course, all information is subject to medical confidentiality.

Information marked with * is optional.

YOUR DATA

Name _____ date of birth _____ place of birth _____

Address _____ zip, city _____

Telephone _____ e-mail* _____

Profession/employer* _____ work telephone* _____

Insurance company name _____

If insured person is differing from patient mentioned above please fill in:

Name _____ date of birth _____

Do you suffer or have you suffered from the following diseases?

	YES	NO		YES	NO
Asthma	O	O	Heard Attack	O	O
Lung Diseases	O	O	Cardiac Insufficiency	O	O
Tuberculosis	O	O	Myocarditis	O	O
Glaucoma	O	O	Heard Arrhythmia	O	O
Rheumatism	O	O	Heard Valve Replacement	O	O
Osteoporosis	O	O	Hypertension	O	O
HIV-Infection	O	O	Hypotension	O	O
Thyroid Diseases	O	O	Angina pectoris	O	O
Hepatitis	O	O	Stroke/Apoplex	O	O
Epilepsy	O	O	Blood Diseases	O	O
Diabetes	O	O	Bleeding Disorders	O	O
Hospital bug MRSA	O	O			
Tumor Diseases/Cancer	O	O	Do you wear a pacemaker?	O	O
			Did you have heart surgery?	O	O

please turn

If you are under treatment for any of these conditions:

Your doctor	address	telephone

Other medically important information:

Do you have allergies? O **YES** O **NO** if yes, against what? _____
Do you have an allergy-pass? O **YES** O **NO**

Do you take medication on a Regular basis? O **YES** O **NO** if yes, which? _____
Do you have a medication-pass? O **YES** O **NO** _____

Do you smoke? O **YES** O **NO**

Are there other Addictions? O **YES** O **NO** if yes, which? _____

Is there a degree of care? O **YES** O **NO** if yes, which? _____

Are you pregnant? O **YES** O **NO** if yes, in which week? _____

other information/other diseases:

_____

Other dental information:

Dental X-Rays taken before? O **YES** O **NO** Date: _____
Do you have a x-ray-pass?* O **YES** O **NO**
Do you have a Bonusheft from you insurance?* O **YES** O **NO**
Do you have dental implants?* O **YES** O **NO**
If yes: do you have an implant-pass?* O **YES** O **NO**

Would you like to be reminded of your semi-annual check-up-dates?*
O **YES** O **NO** if yes by O call O e-mail

How did you hear about our practice?* _____

Advice on the ability to drive after dental appointments:

We inform you that after dental treatment your ability to drive may be impaired for up to 24 hours, both by the treatment itself and by the influence of injections or other medicines. On request, we will gladly call you a taxi.

Bonn, _____ signature_____