MEDICAL HISTORY

mbzwei
PRAXIS FÜR ENDODONTIE

Dear patient!

A warm welcome to our practice. Before we engage in a discussion about your dental needs, we need some information about your general state of health in addition to your personal details. This is important to ensure an appropriate and risk-free treatment. We therefore request that you carefully and conscientiously complete this survey form which will be added to your personal records. All your information is subject to the dentist's professional duty to maintain confidentiality, and is therefore treated with strict confidentiality. Moreover, we are serious about observing the provisions of the European Data Protection Regulation (GDPR). You will find a notice of our detailed data protection information in the waiting room. Please inform us promptly about any changes to your state of health, your address as well as your insurance status.

PATIENT

Surname | Name | Date of birth

Street/House number | Postal code/City | Mobile | Email

INSURED PERSON

Different person responsible for payment

Surname | Name | Date of birth

Street/House number | Postal code/City | Mobile | Email

INSURANCE

- ☐ **Statutory insurance**
- ☐ Private supplementary dental insurance
- ☐ **Private insurance**
- ☐ eligible for benefit
- ☐ base rate
- ☐ standard rate

How did you hear of us?

- ☐ Google
- ☐ Jameda
- ☐ Recommended by .....
- ☐ Location in Pasing medical centre
- ☐ Referral by family dentist
- ☐ .....

GENERAL STATE OF HEALTH

- ☐ Pre-existing conditions/Immunosuppression: .....
- ☐ Allergic to: .....
- ☐ Medication: .....

☐ Bisphosphonate	☐ Blood thinner	☐ MRSA-hospital pathogen
☐ Diabetes	☐ Creutzfeldt-Jakob-disease (CJD)	☐ Hepatitis
☐ Cardiovascular disease	☐ Cardiac pacemaker	☐ Heart disease record card
☐ Cancer	☐ HIV/Aids	☐ Tuberculosis (TBC)
☐ Pregnancy	☐ Smoker	

- ☐ When was the last X-ray of your teeth? .....

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

Date | Signature