Zahnarztpraxis
Dr. Dana L. Marian

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Dear Patient,

We are pleased that you have chosen our dental office and we will do everything to ensure that you are satisfied with this decision in the long term.

By answering the following questions thoroughly, you would provide us with information about your general state of health. This will allow us to plan your treatment individually. Rest assured, your information is subject to medical confidentiality.

Thank you for your trust.

Kind regards.

Your dental office team,
Zahnarztpraxis Dr. Dana L. Marian

First name, Surname: _____ Date of birth: _____

Street/No., ZIP Code/City: _____

Phone Number: _____

E-Mail: _____

Profession: _____

Health insurance: ☐ Private at _____

☐ Public/Statutory health insurance: _____

☐ Member ☐ Voluntarily insured ☐ Pensioner

☐ Family Insurance; Insurance Owner: _____

Date of birth: _____

Name / address of your recommending doctor:

_____

On whose recommendation do you come to us?

_____

What needs would you like us to address?

_____

Are you allergic? ☐ No ☐ Yes, to _____

Do you have an allergy passport? ☐ No ☐ Yes

Do you have any drug intolerance?

☐ No ☐ Yes, against _____

Please select which health conditions apply to you:

☐ High/Low blood pressure

☐ Heart disease

☐ Diabetes

☐ Lung disease (*Pulmonary / Respiratory)*

(which?) _____

☐ Kidney disease

☐ Thyroid disease

☐ Liver disease

☐ Gastrointestinal disease

☐ Epilepsy

☐ Bleeding tendency (*Hemophilia / Increased bleeding propensity)*

☐ Hepatitis / Jaundice

For female patients only: Are you pregnant? ☐ No

☐ Yes. In which month? _____

HIV positive ☐ No ☐ Yes

Other diseases ☐ No ☐ Yes (which?)

_____

First name, Surname: _____

Are you taking any medications (e.g. anticoagulants)?

☐ No ☐ Yes (which?) _____

Have you experienced any complications after anesthetic injections, tooth removal or other dental procedures? ☐ No ☐ Yes (which?)

_____

When was your last X-ray? _____

Do you currently have toothache? ☐ No ☐ Yes

Have you noticed any disease of the gums? ☐ No ☐ Yes

Do your jaw joints crack when you chew or yawn? ☐ No ☐ Yes

Are you satisfied with the appearance of your teeth? ☐ No ☐ Yes

Do you often have headaches or neck pain? ☐ No ☐ Yes

In your own interest, we still ask for your approval of the following:

INFORMATION FROM YOUR HEALTH INSURANCE COMPANY

You consent to the fact that we may obtain the necessary information for your treatment from your health insurance company ☐ **YES** ☐ No

RECALL

You agree to letting us notify you and make arrangements for your follow-ups. So you no longer have to worry about appointments for check-ups or preventive measures ☐ **YES** ☐ No

I confirm that the information I have provided is accurate and complete.

_____ _____

Date Signature