ZAHNARZTPRAXIS
DR. SCHÖBERLEIN

Die Zahnärzte am Rotkreuzplatz

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medical history form

The practice team Dr. Schöberlein would like to welcome you as a new patient. We are pleased to support you with advice and practical help

last name, first name | date of birth

address

phone (privat/ mobil) | phone (business)

E- Mail | profession

insurance

family doctor

If patient and payer are not identical, please complete the following details:

last name, first name (guardian) | date of birth

address

Informed consent in the treatment of minors
If the patient has not yet reached the age of 18, the consent of parent or guardian is required for a treatment (except in acute pain management):

date: | guardian

_____ | _____

_____

Please answer the following questions about your health as accurately as possible:

Heart Failure	☐ Yes ☐ No	
Coronary heart disease	☐ Yes ☐ No	
Heart attack	☐ Yes ☐ No	
Cardiac arrhythmia	☐ Yes ☐ No	
Pacemaker	☐ Yes ☐ No	
Heart surgery	☐ Yes ☐ No	
Valvular heart disease	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	
Low blood pressure	☐ Yes ☐ No	
Hypoperfusion central nervous system	☐ Yes ☐ No	
Bleeding disorder organically	☐ Yes ☐ No	
Or because of medication e.g. by ingesting: Marcumar / Plavix / ASS	☐ Yes ☐ No	_____
Asthma	☐ Yes ☐ No	
Lung disease	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	
Rheumatism	☐ Yes ☐ No	
Artificial joints	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Renal impairment	☐ Yes ☐ No	
Fainting tendency	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	☐ A ☐ B ☐ C
Tuberculosis	☐ Yes ☐ No	
AIDS/HIV	☐ Yes ☐ No	
MRSA	☐ Yes ☐ No	
other:	☐ Yes ☐ No	
_____		
Tumors, cancer	☐ Yes ☐ No	
Organ/Region:_____		
Use of bisphosphonates	☐ Yes ☐ No	i.V. ☐ oral ☐
Radio- or - Chemotherapy	☐ Yes ☐ No	
Liver disease	☐ Yes ☐ No	
Gastrointestinal disease	☐ Yes ☐ No	
Dialysis	☐ Yes ☐ No	
Glaukoma (green Star)	☐ Yes ☐ No	
Osteoporosis	☐ Yes ☐ No	

Allergies

painkiller	☐ Yes ☐ No	
local anesthetics	☐ Yes ☐ No	
medicament	☐ Yes ☐ No	if yes, which?
		_____
Antibiotics	☐ Yes ☐ No	if yes, which?
		_____
Other: (e.g. Metals, Materials)	☐ Yes ☐ No	

_____

General Information:

Drug use	☐ Yes	☐ No	if yes, which?
			_____
Consumption of alcohol	☐ Yes	☐ No	
Smoker	☐ Yes	☐ No	
Regular medication	☐ Yes	☐ No	if yes, which?
			_____
			_____
Previous X-ray examinations	☐ Yes	☐ No	if yes, Date
			_____
Pregnancy	☐ Yes	☐ No	if yes, which Month?

Recall

Time goes by so quickly, so you do not forget your semiannual checkup and / or prophylaxis (teeth cleaning), we offer a reminder service.

☐ I want the reminder service by:

Phone: _____

E-Mail: _____

Letter: _____

Important Information:

- All information is subject to medical confidentiality and data protection regulations and are therefore treated as strictly confidential. I agree to the storage of my personal data.
- I release Dr. S. Schöberlein from medical confidentiality as far as it is necessary for data processing by the tax consultant.
- I undertake to inform you immediately of any changes during the treatment period.
- I undertake to respect agreed deadlines or cancel at least a day in advance, otherwise be made in the amount of € 250.00 per hour lost in account.
- I confirm with my signature that I have read and understood the printed information.

How did you hear about our practice? _____

Place, Date

Patient's /Guardian's Signature