

ZAHNARZTPRAXIS DR. SCHÖBERLEIN

Die Zahnärzte am Rotkreuzplatz

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www.Dr-Schöberlein.de

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

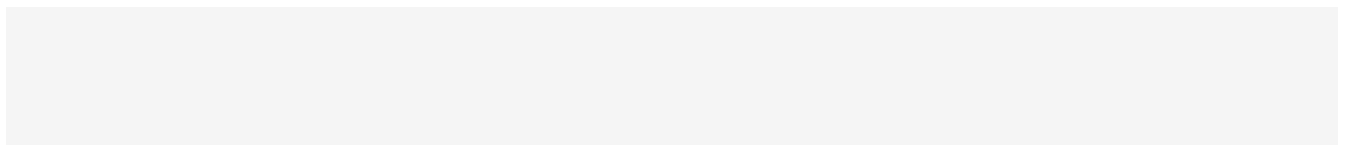
address

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 Yes No
 e.g. by ingesting:
 Marcumar / Plavix / ASS

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
 Tuberculosis Yes No
 AIDS/HIV Yes No
 MRSA Yes No
 other: Yes No

A B C

Tumors, cancer Yes No
 Organ/Region: _____
 Use of bisphosphonates Yes No
 Radio- or - Chemotherapy Yes No
 Liver disease Yes No
 Gastrointestinal disease Yes No
 Dialysis Yes No
 Glaukoma (green Star) Yes No
 Osteoporosis Yes No

i.V. oral

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