schwan-wilhelmy-wunderlich

Medical Record

Dear patient, welcome to our dental practice.

In addition to personal information we need some information about your general health status, because some illnesses might have implications for your treatment. In due course we will take the opportunity to talk about your individual wishes, but in the first instance please take your time to fill in this form, which we shall add to your records. Of course this information will be treated confidentially.
And also in the future, please tell us of any changes in your medical status.

Patient

Surname, Name: _____ Date of Birth: _____

Street, House No.: _____ Postal Code, City: _____

Telephone: _____ Mobile: _____

Email: _____ Profession: _____

Insurance: _____

State/Compulsory Insurance ☐ Private Insurance ☐
Additional/Extra private Insurance ☐

Insured (if different from patient data)

Surname, Name: _____ Date of Birth: _____

Street, House No.: _____ Postal Code, City: _____

Name and address of your family doctor

Name: _____ City: _____

Telephone: _____

Covid-19-history

Do you suffer from taste or smell impairments? ☐
Have you had a fever, cough, or shortness of breath in the past 14 days? ☐
Have you had contact with corona infected people or suspected cases in the past 14 days? ☐

Did your ever have

Trauma to the head ☐
High blood pressure ☐
Low blood pressure ☐
Diabetes ☐
Bleeding disorder ☐

Tinnitus ☐
Epilepsy ☐
Narrow angle glaucoma ☐
Tuberculosis ☐
HIV (Aids) ☐
Psychological illnesses ☐
Operations to the head? ☐
Where?

Hepatitis ☐
If yes, what type? ☐ A ☐ B ☐ C
Allergies ☐
Which ones and against?

Osteoporosis ☐
Do you need an endocarditis prophylaxis? ☐
Tumour/Cancer? ☐
If yes, where?

Any other illnesses? ☐
Which ones?

Please turn over →

Do you take any of the following medications?

Heart medication: _____ ☐
Painkillers: _____ ☐
Blood thinners (Aspirin, Marcumar): ☐
_____
Any other? ..... ☐
Which ones?

Bisphosphonates: _____ ☐
Did you ever have an allergy against any medication or injection? ..... ☐
If yes, which one?
_____

Is there anything else that you want to draw our attention to?

For our female patients

Are you pregnant? *How long?* _____ ☐

What is your chief complaint that brings you to us?

Last but not least

Do you grind your teeth? ..... ☐
Do you have a lot of stress? ..... ☐
Do you take drugs? ..... ☐

Do you smoke? ..... ☐
Do you snore? ..... ☐

Do you have any special wishes for your dental treatment?

Do you want to be reminded about your next check-up? ☐ Yes ☐ No
If yes, by which method? ☐ Email ☐ Mail ☐ Phone call

How did you find our dental practice?
☐ Recommended by: _____ ☐ Telephone directory ☐ Internet

Anything else: _____

Notes regarding roadworthiness after dental treatment

Please note that, in certain circumstances, your roadworthiness after dental treatment can be affected for up to 24 hours. This may on the one hand be caused by the treatment itself or on the other hand by injections, or medication. If you wish we can order a taxi for you to bring you home safely.

Place, Date

Signature

Dear patient, our dental practice works with scheduled appointments. This means that we reserve the appointed time just for you. This also means that we kindly ask you, if necessary, to cancel your appointment at least 48 hours in advance, so that we can pass the appointment on to someone else.

Failure to do may mean that we have to charge you a cancellation fee. This will not apply if the cancellation is not your fault. Please note, that we are obliged to give priority to emergency pain patients, which might cause some waiting time.

Place, Date

Signature