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: ______________________

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