praxisklinik münchen nord®

Medical history

(please fill out complete)

Patient:

Name, First name	Date of birth ☐ M ☐ F
Street, Number	Postal code, City
Phone (privat)	Mobile number
Phone (business)	E-Mail

Insured under:

Name, First name	Date of birth ☐ M ☐ F
Street, Number	Postal code, City

Insurance:

☐ Public health insurance: _____

☐ additional insurance coverage

☐ Privat health insurance: _____

☐ Basic tariff ☐ Granted Social Aid (additional insurance)

Declaration of agreement for treatments of minor

If the patient hasn´t reached the age of 18, the concent of the parent or legal guardian is nessesary for all treatments acute, with the exeption of acute pain or emergencies.
With my signature to this Questionaire I grant my consent.

Dear Patient,
for an ideal adapted dental treatment we need some information regardingyour medical history. Please fill out the questionnaire complete.

Do you have any common pain? ☐ yes ☐ no Which?_____
Are you under medical treatment? ☐ yes ☐ no Which? _____
Do you take any pharmaceuticals? ☐ yes ☐ no Which?_____
(Do you need more space? Please use the back side)
Are you allergic to anything? Do you have an allergy passport? ☐ yes ☐ no Which?_____

Heart-Circulation-Disorders	current/ past please specify both		
High blood preasure	☐ yes	☐ no	
Low blood preasure	☐ yes	☐ no	
Have you had a heart attack	☐ yes	☐ no	When: _____
Cardiac valve defect/-replacement	☐ yes	☐ no	
Heartsurgery	☐ yes	☐ no	Which?: _____
Cardiac peacemaker	☐ yes	☐ no	Since: _____
Blood coagulation disorder	☐ yes	☐ no	
Apoplectic Stroke	☐ yes	☐ no	When? _____

Infectious disease	current/ past please specify both	
HIV	☐ yes	☐ no
Hepatitis A	☐ yes	☐ no
Hepatitis B	☐ yes	☐ no
Hepatitis C	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no

Other diseases	current/ past please specify both		
Asthma	☐ yes	☐ no	
Diabetes	☐ yes	☐ no	
Epilepsy	☐ yes	☐ no	
Addiction to faint	☐ yes	☐ no	
Rheumatism	☐ yes	☐ no	
Arthritis/ Arthrosis	☐ yes	☐ no	
Osteoporosis	☐ yes	☐ no	
Tumor	☐ yes	☐ no	
Chemotherapy	☐ yes	☐ no	Wann? _____
Kidney disease	☐ yes	☐ no	
Thyroid gland disorder	yes	no	☐ hyperfunction ☐ hypofunction

Do you have any diseases which are not listed here?
If yes, please note here
_____

Do you consume drugs?	☐ yes	☐ no	
Do you drink alcohol?	☐ yes	☐ no	☐ very often ☐ often ☐ rarely
Do you smoke?	☐ yes	☐ no	☐ 0-10 Cig/day ☐ über 10 Cig/day
For Women: Are you pregnant?	☐ yes	☐ no	Which week? _____

How did you hear about this clinic?

☐ Internet ☐ recommended by friends: _____

☐ Clinic Signage ☐ Others: _____

What are your expectations/wishes for coming here?

Do you have special wishes?

Do you wish informations about implantation? ☐ yes ☐ no

Do you wish informations about dental asthetic treatments? ☐ yes ☐ no

When was your last prophylaxis treatment? Year: _____

When was the last x-ray taken from your teeth? Year: _____

Important Informations:

- All Information given is subject to complete medical confidentiality, the privacy protection registrations are strictly confidential. I agree with the retention of my personal information and medical history.
- I promise to inform the clinic about any and all changes to my medical condition during my time as a patient.
- I agree to keep all my appointments or to cancel them at least 2 days before, otherwise costs thereby incurred could be charged to my account.
- With my signature I confirm that I have read and understood all questions and answered truthfully.

Unterschleißheim, _____ _____

Date Signature