Dear Patient,

welcome to the dental surgery Dental.Island

We are glad that you entrust us your smile and your dental health!

It is our aim to provide you with the best possible individual treatment. Therefore, we would like to ask you to take a few minutes to read this questionnaire carefully and to fill it out as accurately as possible. We will talk about the most important questions and answers in detail with you in a moment.

The information you provide with this questionnaire will only be used to optimize your treatment and will be kept confidential and not disclosed to any third party without your permission.

Please inform us about any changes as it may negatively affect your treatment and may cause serious health issues.

1 Personal information

PATIENT'S CONTACT DETAILS

Surname, Given names _____ Date of birth _____ Place of birth _____ ☐ m ☐ f

Current address _____

Postal/Zip Code _____ City/Country _____

Phone _____ Mobile _____

E-mail _____

I ...

☐ **am covered by the statutory health insurance**

☐ **have an additional insurance**

Which insurance company?

_____

_____

☐ **have a private health insurance**

Which insurance company?

_____

_____

_____

If you are not the insurance policy holder please provide further details:

INSURANCE POLICY HOLDER

Surname, Given names _____ Date of birth _____ ☐ m ☐ f

Current address _____

Postal/Zip Code _____ City/Country _____

Name of family doctor

Contact data

If you have your family doctor's address and phone number at hand, please fill it in here.

Were X-ray images of your teeth and/or head taken before?

☐ Yes ☐ No

When have they been made and who has done the X-ray images?

If you remember the date and name of the person who took the images, please fill it in here.

2 Your concern

WHAT IS THE REASON OF YOUR VISIT?

- ☐ Routine check
- ☐ Treatment of pain
- ☐ Searching for advice
- ☐ „Second opinion"
- ☐ New dental prosthesis
- ☐ Bleeding gums
- ☐ Gnashing
- ☐ _____
- ☐ _____

3 Specific questions concerning your health

MEDICATION

Are you taking any medication on a regular basis? ☐ Yes ☐ No
If yes, which medication?

Are you taking any blood-thinning medication? ☐ Yes ☐ No
If yes, which medication?

Are you taking any medication against osteoporosis or tumour diseases (for example bisphosphonates)? If yes, which medication? ☐ Yes ☐ No

FOR OUR FEMALE PATIENTS

Are you pregnant? ☐ Yes ☐ No
If yes, which month?

ALLERGY

Do you have any hypersensitivity or allergery, in particular in regard to any medication? ☐ Yes ☐ No
If yes, please specify.

Do you have an allergy pass? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol or other drugs? ☐ Yes ☐ No
If yes, please specify.

Do you consume stimulants or sedatives? ☐ Yes ☐ No
If yes, please specify.

4 General questions concerning your health

MEDICAL TREATMENT

Are you under medical treatment at the moment? ☐ Yes ☐ No
If yes to which illness?

HEART COMPLAINT

Cardiac insufficiency? ☐ Yes ☐ No
Cardiac pacemaker/ Artificial heart valve? ☐ Yes ☐ No
State after a heart attack? ☐ Yes ☐ No
Congenital heart defect/ acquired heart defect? ☐ Yes ☐ No
Other?

VASCULAR DISEASES

High blood pressure? ☐ Yes ☐ No
Low blood pressure? ☐ Yes ☐ No
Other?

INFECTIOUS DISEASES

Hepatitis A/B/C? ☐ Yes ☐ No
Tuberculosis? ☐ Yes ☐ No
HIV? ☐ Yes ☐ No

METABOLIC DISEASES

Diabetes? ☐ Yes ☐ No
Thyroid disorders? ☐ Yes ☐ No
Kidney diseases? ☐ Yes ☐ No
Gastric-infections / Intestinal illnesses? ☐ Yes ☐ No
Chronic liver disease? ☐ Yes ☐ No
Other?

DISORDERS OF THE NERVOUS SYSTEM

Epileptic fits? ☐ Yes ☐ No
Depressions? ☐ Yes ☐ No

OTHER DISEASES AND INFORMATION

Rheumatism? ☐ Yes ☐ No
Lung diseases /Asthma? ☐ Yes ☐ No
Nasal diseases / Paranasal sinuses deseases? ☐ Yes ☐ No
Do you have any other diseases? ☐ Yes ☐ No
If yes, please specify

HOW DID YOU FIND OUT ABOUT US?

☐ Recommendation from _____ ☐ Jameda.de ☐ Google/Yahoo/other ☐ Homepage
☐ Doctor's referral _____ ☐ Facebook ☐ Other _____

DO YOU WANT TO BE REMINDED OF YOUR NEXT APPOINTMENT?

☐ Yes ☐ No

If yes, how? ☐ via phone call ☐ via e-mail ☐ via SMS

In case you are unable to attend your appointment we would like to ask you to inform us **at least 24 hours before** in order to reschedule. Otherwise we would need to charge the costs caused by not attending the appointment.

Be cautious after a dental treatment

Be aware that the dental treatment or the received medication might affect your ability to drive a car for up to 24 hours. You might also experience a drowsiness which might affect your conscious reactions. Please be careful and ask us for any further information or if you need help.

I have filled out this questionnaire to the best of my knowledge and confirm with my signature that the provided information are complete and correct. Furthermore, I will inform you if there are any changes in the provided information. Furthermore, I agree that the dental surgery Dental Island may inform me at regular intervals about important medical check-ups and news (e.g. professional tooth cleaning) via e-mail. I can change or revoke this information at any time.

Place, Date _____ Signature _____

Send form to practice