Alstertal Zahnteam

Uetzmann, Kreymborg & Partner

Patient

Surname | Name | Date of Birth

Insured person

Surname | Name | Date of Birth

Address

Postal Code | City | Street

Phone | Mobile | e-mail

Profession

Profession | Company

Insurance

Health insurance | additional dental insurance

Please tick all that apply:

Cardiovascular deseases

yes	no	
○	○	cardiac infarction in past
○	○	cardiac insufficiency
○	○	heart muscle disease
○	○	coronary heart disease
○	○	cardiac arrhythmia
○	○	previous coronary artery bypass
○	○	cardiac pacemaker

yes	no	
○	○	low blood pressure
○	○	high blood pressure
○	○	angina pectoris
○	○	circulatory disorders
○	○	previous stroke (apoplexy)

other:

Haematopoietic deseases

yes	no	
○	○	anemia
○	○	bleeder (haemophiliac)

other:

Eye deseases

yes	no	
○	○	cataract
○	○	glaucoma

Respiratory diseases

yes	no	
○	○	bronchial asthma
○	○	chronic bronchitis

other:

Deseases of the intestinal tract

yes	no	
○	○	stomach/gastric deseases
○	○	intestinal/enteric deseases
○	○	kidney deseases
○	○	dialysis

other:

please turn over!

Please tick all that apply:

Hepatopathy

yes no
- ◯ ◯ jaundice/ icterus
- ◯ ◯ hepatitis

Musculoskeletal system

yes no
- ◯ ◯ rheumatism
- ◯ ◯ osteoporosis

Neurological disorders

yes no
- ◯ ◯ epilepsy
- ◯ ◯ headaches
- ◯ ◯ migraine
- ◯ ◯ depressions

Metabolic diseases

yes no
- ◯ ◯ diabetes
- ◯ ◯ hypothyroidism
- ◯ ◯ hyperthyroidism

Infections

yes no
- ◯ ◯ HIV
- ◯ ◯ tuberculosis

other: ____________________

Tumor deseases

yes no
- ◯ ◯ tumor deseases, Jear: __________
- ◯ ◯ chemotherapie
- ◯ ◯ radiotherapy

Other relevant, medicinal information:

yes no
- ◯ ◯ Do you suffer from any other desease not mentioned above? If yes, which one?

____

- ◯ ◯ Allergies (allergic reactions, drug incompatibility, intolerance of an material?)
If yes, which one?

____

- ◯ ◯ regular intake of medication? If yes, which one?

____

- ◯ ◯ current pregnancy??
- ◯ ◯ Do you smoke? If yes, how many per day?: __________
- ◯ ◯ Did you have any undesirable side effects after dental local anaesthesia?
- ◯ ◯ Do you want us to remind you of any dental appointments in future?

How did you take notice of our dental practise?

____

Please notify that your fitness to drive might be reduced after a dental treatment itself or dental anaesthesia.

If you cannot keep the appointment you made, we kindly ask you to cancel it early enough, otherwise we might charge a fee, it is a amount being laid out by GOZ.

____________________ ____________________

Date Signature