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Hello and welcome to our dental office!

To be able to provide you with individual and risk-free dental care we ask you to give us some personal as well as medical data.

Medical confidentiality applies.

Personal data

Patient
Mr/ Mrs _____ _____ _____
Name First name Birthday

Address _____
Street, no, postal code, city

Phone (home) _____

Phone (work) _____

Mobile _____

Email address _____

Health insurance ☐ "gesetzlich" _____ ☐ EU insurance

☐ private _____

co-insured with _____ _____
Name Birthday

Patients with "gesetzliche" insurance

We require your health insurance card with every appointment at our office. If you can't provide the card within 14 days of the treatment we consider you as a private patient and you will receive an invoice according to GOZ (Gebührenordnung für Zahnärzte/ dental fee schedule) standards.

How did you get to know about our dental office?

☐ Telephone book ☐ Internet ☐ passing by ☐ Yellow pages ☐ Friends/ relatives _____

☐ I wish to be included into the recall system and get a reminder by phone to schedule a biannual appointment.

Family physician/ specialist _____
Name

Address _____ phone _____
Street, no

_____
Postal code, city

A note on time management:

We constantly strive to spare you excessive waiting time. Thus, we ask you to **cancel appointments minimum 24 hours in advance** if you are not able to keep them. **We are entitled to charge for missed appointments according to GOZ standards even if you are not privately insured.** Please note that we have to integrate patients with pain into our schedule and thus delays may occur.

Data security:
Information about the elicitation and processing of personal data according to the EU General Data Protection Regulation (GDPR/ DSGVO) may be obtained at our website or our clinic's reception desk at any time.

Frankfurt, date _____ Signature _____

Please turn over

Medical data

Medical treatment: Are you under any medical treatment at the moment Yes ☐ No ☐

If yes, because of which illness? _____

Did you have an operation? No ☐ Yes ☐ If so, when _____ why_____

Do you have artificial joints? No ☐ Yes ☐ If so, where _____

Do you smoke? No ☐ Yes ☐ If so, how much? _____ packs per day

Do you take stimulants, tranquilizers or other such substances? No ☐ Yes ☐

If so, which? _____

Medication: Which medications do you have to take regularly? _____

_____

Allergies: Do you have an allergy or sensitivity towards medications and/ or materials? Please list here: _____

Do you have an allergy pass card?	Yes ☐	No ☐
Asthma	Yes ☐	No ☐

Cardiac diseases:			
	Endocarditis	Yes ☐	No ☐
	Cardiac insufficiency	Yes ☐	No ☐
	Irregular heartbeat (Arrhythmia)	Yes ☐	No ☐
	Angina pectoris	Yes ☐	No ☐
	Cardiac pacemaker, valvular transplant	Yes ☐	No ☐
	Bypass	Yes ☐	No ☐
	Stent	Yes ☐	No ☐

Circulatory disorder/ blood diseases:				
	Blood pressure	too high ☐	too low ☐	normal ☐
	Cardiac infarction		Yes ☐	No ☐
	Bleeding tendency (Haemophilia)?		Yes ☐	No ☐
	Anaemia		Yes ☐	No ☐
	Do you take anticoagulants?		Yes ☐	No ☐

Metabolic diseases:			
	Diabetes	Yes ☐	No ☐
	Gastro-intestinal disease	Yes ☐	No ☐
	Renal dysfunction	Yes ☐	No ☐
	Thyroid disorder	Yes ☐	No ☐

Nervous system:	Epileptic seizures		Yes ☐	No ☐
Infectious diseases:	Hepatitis A/ B/ C		Yes ☐	No ☐
	Tuberculosis		Yes ☐	No ☐
	Have you been tested for HIV?	No ☐	Yes ☐	result: _____
Eye disease:	Glaucoma		Yes ☐	No ☐

Do you suffer from migraine or headaches? Yes ☐ No ☐

Do you grind your teeth? Yes ☐ No ☐

In case of pregnancy: how far along are you? _____ week/ month

Anything else we should know? _____

Have you been x-rayed in the facial area within the last year? Yes ☐ where? _____ No ☐

Our modern equipment ensures as low a radiation dose as possible.

Thank you for your cooperation! Please let us know any changes to the above data immediately. With your signature you agree to the exchange of medical data between our dental office and the orthodontic office of Edward Jahn.

Frankfurt, date _____ Signature _____