

Case History

We are pleased to welcome you to our surgery. To be able to give you the best possible treatment we need some information about yourself and your health status. General illnesses can also have an impact on your dental health and require various treatment options. All information given is subject to medical confidentiality and data privacy requirements and will be handled strictly confidential.

Personal data

Name / Surname	Date of birth
Street/ number	Postal code / City
Phone-No. private	Phone-No. work
E-Mail	
Profession / Employer	

Insurance

Health insurance

statutory health insurance yes no
 private insurance yes no
 Base rate yes no
 additional insurance yes no
 entitled to aid yes no

If you are not insured by yourself, please give the information of the insurance holder.

Name / Surname	Date of birth
Street/ number	Postal code / City
Place and date of issue	Signature patient / Payer
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Please turn round!

General health situation

Have you ever suffered from

- High blood pressure yes no
 Low blood pressure yes no
 Blood clotting dysfunction yes no
 Heart diseases yes no

If so, which one: _____

- Stroke yes no
 Diabetes yes no
 Gum bleeding yes no
 Tinnitus yes no
 Epilepsy yes no
 Glaukoma yes no
 Thyroid disease yes no
 Rheumatism yes no
 Tuberculosis yes no
 HIV yes no
 Hospital germ MRSA yes no
 Osteoporosis yes no
 Hepatitis yes no

If so, which type? A B C

- Allergies yes no

If so, against what? _____

Other illnesses

Which medication are you taking

- Cardiovascular drugs
 Analgesics
 Blood-thinning medications
 Antidepressants
 Cortison
 Bisphosphonate
 Other medications:

Have you ever suffered from an intolerance to drugs or injections? yes no

If so, against which?

Do you carry

- a pacemaker yes no
 a defibrillator yes no

A question to our female patients

Are you pregnant? yes no

If so, in which week? _____

Do you have a X-ray passport? yes no

Are you a smoker? yes no

Are you under supervision? yes no

Dental health

What can we do for you

- Medical check-up Consultation Pain management New dentures Referral Second opinion

Others: _____

How satisfied are you with the positioning of your teeth? ja nein

Do you grind your teeth? ja nein

Do you have problems with your gum? (Bleedings, gum recession) ja nein

Are you suffering from chronic bad breath or bad taste in your mouth? ja nein

Have your teeth been checked regularly? ja nein

Have your teeth been cleaned professionally? ja nein