Medical History

PRAXIS
Dr. med. dent. Kreller
Dr. med. dent. Joos

Dear Patient,
welcome to our dental practice!

Please fill out this medical history sheet so that we can treat you as you wish and in accordance with your state of health. We hope you understand that we will update this questionnaire regularly. This is in our common interest. Of course, your information is strictly subject to medical confidentiality according to §203 STGB and your personal data will be treated in accordance with the requirements of federal data protection.

If you are not sure, please do not hesitate to contact us.

Personal Data

Name	Job
Surname	Birthday
Address	Phone Number
Postcode/ Town	E-Mail

How did you hear about us?

☐ Friends / acquaintances / relatives Who? _____

☐ Internet: Google, Facebook ☐ Jameda ☐ Doctolib

Are you afraid of going to the dentist?

☐ No, not at all ☐ I am very nervous

☐ I am a little nervous ☐ I am very scared

Your insurance status:

☐ Statutory health insurance ☐ Private health insurance

Name: _____

☐ I hereby confirm that I am not insured under the basic, standard or student tariff of: private health insurance.

General medical history

(Please check where applicable ☒)

Name & address of your Doctor:

_____

Are you currently under medical treatment? ☐ No ☐ Yes
If yes, which doctor?

_____

Infectious diseases:

HIV/ AIDS	☐ No	☐ Yes
Hepatitis A, B, C	☐ No	☐ Yes
Tuberkulose	☐ No	☐ Yes

Allergies / intolerances (latex, dyes, etc.):

_____

Do you have ... if so, what medication do you take ?:

- **Heart - circulatory disorders or diseases** ☐ No ☐ Yes
  Medication: _____
- **Blood coagulation disorders (e.g. aspirin, marcumar)** ☐ No ☐ Yes
  Medication: _____
- **Respiratory diseases (e.g. bronchial / allergic asthma, COPD)** ☐ No ☐ Yes
  Medication: _____
- **Osteoporosis (bisphosphonates as tablets or half-yearly injection)** ☐ No ☐ Yes
  Medication: _____
- ***Diabetes Mellitus I/ II*** ☐ No ☐ Yes
  Medication: _____
- **Thyroid Disease** ☐ No ☐ Yes
  Medication: _____
- **Rheumatism** ☐ No ☐ Yes
  Medication: _____
- **Epilepsy** ☐ No ☐ Yes
  Medication: _____
- **Renal Dysfunction** ☐ No ☐ Yes
  Medication: _____
- **Tumor Diseases** ☐ No ☐ Yes
  Medication: _____
- **Fainting Tendency** ☐ No ☐ Yes
  Medication: _____
- **Other Diseases** ☐ No ☐ Yes
  _____

General Information:

- **Do you smoke?** ☐ No ☐ Yes
  If yes, how many cigarettes / daily: _____
- **Are you pregnant?** ☐ No ☐ Yes
  If yes, which month: _____

Dental medical history

(Please check where applicable ☒)

Have you had any unusual reactions to a dental syringe?

☐ No ☐ Yes

Do you have problems with your gums (bleeding, falling, burning)?

☐ No ☐ Yes

Do you observe tooth loosening?

☐ No ☐ Yes

Do you have hypersensitive teeth (e.g. cold or sweet)?

☐ No ☐ Yes

Do food remnants bite between your teeth?

☐ No ☐ Yes

Do you often have bad taste in your mouth or bad breath?

☐ No ☐ Yes

Have you had periodontitis treatment in the past?

☐ No ☐ Yes

Have you had an accident with injuries to the head or neck?

☐ No ☐ Yes

Do you have pain or problems opening your mouth or chewing?

☐ No ☐ Yes

Are you gritting your teeth or pressing hard on each other?

☐ No ☐ Yes

Rub, crack or pinch the jaw joints during movements?

☐ No ☐ Yes

Have your teeth been X-rayed within the past year?

☐ No ☐ Yes

Are you satisfied with the aesthetics of your teeth?

☐ Yes ☐ No

Would you like to change the aesthetics of your teeth?

☐ Yes ☐ No

If yes, what? _____

Should we remind you of your regular checkups and the dates for your professional teeth cleaning?

☐ Yes ☐ No

With my signature I confirm that I have answered all information according to my current level of knowledge.

✘ _____

Date ***Signature of Patient*** ***Signature of Doctor***

If you have to cancel an appointment, we are happy to give it to other patients who are urgently waiting. However, this is only possible if you let us know in time by **phone, e-mail or via Doctolib**, this means **24 hours** before your appointment.

We therefore kindly point out that we will notify you in the event of non-cancellation or late cancellation. §§ 304, 683 BGB a reimbursement of expenses up to **85 €/ half a hour** plus postage can be charged.

This claim for reimbursement of additional expenses is incurred regardless of the circumstances of the failure. It is not a claim for damages, but a claim for reimbursement of costs. In this case, we would like to agree with you a customary, proven and already legally confirmed regulation, since an appointment with a time commitment corresponds to a mutual contractual agreement. The declaration of consent is part of this agreement.

Thank you for your understanding.

I agree to the above agreements with my signature.

✘ _____

Signature of Patient