ANAMNESE

Welcome to our dentist surgery

Since general diseases can affect the dental treatment, we ask you to fill in this questionnaire. It will be attached to your personal patient file. The questions in the anamnesis form are legally mandatory and intended to assess your health and adapt our treatment to your state of health.

Patient: surname______________________ first name______________________ date of birth______________

address: street_________________________ post code_______________ residence_______________________

phone________________________ mobile____________________________

email______________________________________

employer_______________________ job_________________________ phone business___________________

Insurance:

- ☐ Legal Insurance
  - ☐ voluntarily insured
  - ☐ supplementary insurance
  - ☐ reimbursement of costs
- ☐ Private Insurance
  - ☐ comprehensive insurance
  - ☐ eligible for aid
  - ☐ base rate

Health Insurance:

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Insurance data: (if they deviate from the patent data, e. g. legal guardian)

surname______________________ first name______________________ date of birth______________

address: street_________________________ post code_______________ residence_______________________

Name and address of your **family doctor**: ____

Health check:

Artificial heart valves	☐yes	☐ no
Or defibrillator	☐yes	☐ no
Heart attack	☐yes	☐ no
If so, when? ______________		
Heart failure	☐yes	☐ no
Irregular heartbeat	☐yes	☐ no
Heart asthma, Angina pectoris	☐yes	☐ no
High blood pressure	☐yes	☐ no
Low blood pressure	☐yes	☐ no
Unconscious inclination	☐yes	☐ no
Oral anticoagulants:Marcumar, NOACs	☐yes	☐ no
Bleeding tendency/ blood disease	☐yes	☐ no
Rheumatism	☐yes	☐ no
Diabetes	☐yes	☐ no
Thyroid disease	☐yes	☐ no
Liver disease (Hepatitis)	☐yes	☐ no
Stomach intestinal disease	☐yes	☐ no
Kidney disease	☐yes	☐ no
Lung disease/ Asthma	☐yes	☐ no
Nasal sinus disease	☐yes	☐ no
Epilepsy	☐yes	☐ no

Do you have any other illnesses?	☐yes	☐ no
If yes, which ___________________________		
Do you have a disease of the immune system?	☐yes	☐ no
If yes, which ___________________________		
Have you had surgery recently?	☐yes	☐ no
If yes, where ___________________________		
Allergies	☐yes	☐ no
If yes, which ___________________________		
Allergy pass	☐yes	☐ no
Are you sensitive to medication?	☐yes	☐ no
If yes, which ___________________________		
Which medications do you take regularly?		
______________________________________		
Are you a Smoker?	☐yes	☐ no
For our female patients:		
Are you pregnant?	☐yes	☐ no
If yes, which week? ____________________		

When were you x-rayed in the head area the last time? ____

PLEASE TURN OVER

Consulting desire:

Professional tooth cleaning	☐yes ☐no	Laser treatment	☐yes ☐no
Lighter teeth (Bleaching)	☐yes ☐no	Dentures treatment	☐yes ☐no
Children prophylaxis	☐yes ☐no		

Note on local anesthesia:
As with all dental treatments, local anesthesia can also cause side effects or intolerances.
By the anesthesia it can e.g. in addition, limited movement of the mouth area can occur.
In addition, in exceptional cases nerve damage may occur, which is temporary in most cases. After the anesthesia and treatment, your ability to drive is also restricted, since the reaction and concentration skills are weakened.

Note on the health insurance card:
If you cannot provide the electronic health card, please submit it within 10 days, otherwise we will have to write a private invoice for our services.

Note for appointment:
We work as an order practice. Therefore not canceled appointments lead to idle times.
Therefore, please cancel the day before the treatment, if you cannot meet your appointment.
If the date is culpably neglected, the case law may charge for this downtime.

Note on privacy:
The information given here is subject to medical confidentiality and data protection. The data will be stored in our in-house data processing and will not be forwarded to third parties without your permission.

Consent of guardians:
With my signature, I consent to the treatment and assure that the other parent, too, agrees with the treatment.

________________ ____

Date Signature Patient / Insured