Zahnarztpraxis Dr. Kraft M.Sc. & Kollegen
Hohlweg 20 · 65396 Walluf · Tel. 0 61 23 / 7 38 38

Welcome to our practice!

Before we talk about your wishes and needs relating to your teeth, we would like to ask you to provide some personal data as well as information about your general state of health. This is important to ensure adequate and risk-free treatment. Any information provided is of course subject to the medical confidentiality obligation.

Patient
Mr. / Ms. / child _____
surname | first name | date of birth

Main insurant _____
surname | first name | date of birth

Address _____
street | no. | phone no.

_____
zip code | city | mobile phone

_____
email

Health insurance _____

Profession _____

Employer _____

Do you wish to be reminded when your next check-up is due?

☐ yes ☐ no

For public health patients:

Please note that you need to present your health-insurance card anytime you visit our practice. If you fail to do so within 14 days after treatment, we will consider you a private patient and you will receive an invoice according to GOZ ("Gebührenordnung für Zahnärzte" - dental fee schedule).

We always try to save you a long wait. Hence we kindly ask you to cancel appointments at least 24 hours prior if you are unable to come. We reserve the right to invoice appointments you have not kept according to GOZ, also if you are a public health patient. Please be aware that patients in pain have to be integrated into our daily schedule, which might sometimes result in delays.

Date _____ Signature _____

please turn

Medical history

Are you currently being treated for a medical condition? ☐ yes ☐ no

If yes, what condition? _____

Name, address and phone number of your general practitioner / medical specialist:

_____

Please list current regular medication: _____

_____

Allergies:	Is there a possible hypersensitivity to any materials or medications?	☐ yes ☐ no
	If so, which ones? _____	
	Do you have an allergy data card?	☐ yes ☐ no
Cardiac diseases:	Cardiac insufficiency?	☐ yes ☐ no
	Irregular heartbeat (arrhythmia)?	☐ yes ☐ no
	Angina pectoris?	☐ yes ☐ no
	Cardiac pacemaker, cardiac valve replacement?	☐ yes ☐ no
	Other? _____	
Cardio-vascular diseases:	High blood pressure (hypertension)?	☐ yes ☐ no
	Low blood pressure (hypotension)?	☐ yes ☐ no
	Have you had a heart attack?	☐ yes ☐ no
	Do you take anticoagulants?	☐ yes ☐ no
	Other? _____	
Vegetative diseases:	Fainting fits?	☐ yes ☐ no
	Do you take stimulants or sedatives?	☐ yes ☐ no
	Other? _____	
Metabolic diseases:	Diabetes?	☐ yes ☐ no
	Gastro-intestinal issues?	☐ yes ☐ no
	Thyroid issues?	☐ yes ☐ no
	Other? _____	
Diseases of the nervous system:	Epileptic fits?	☐ yes ☐ no
	Convulsions?	☐ yes ☐ no
	Other? _____	
Diseases of the blood::	Excessive bleeding (haemophilia)?	☐ yes ☐ no
	Anemia?	☐ yes ☐ no
	Other? _____	
Contagious diseases:	Inflammation of the liver / jaundice (hepatitis)?	☐ yes ☐ no
	Tuberculosis?	☐ yes ☐ no
	Chronic respiratory issues, coughing etc.?	☐ yes ☐ no
	Have you been tested for HIV?	☐ yes ☐ no
	If yes, with what result? _____	
	Other? _____	
Other:	Do you have a joint replacement?	☐ yes ☐ no
X-ray:	Have you had an X-ray of the head/jaw/dental area in the last 12 months?	☐ yes ☐ no
	If yes, where? _____	
Pregnancy:	Are you pregnant? ☐ yes ☐ no	_____ months

Thank you for your assistance. If any of the information provided above changes, please let us know immediately.

Date _____ Signature _____