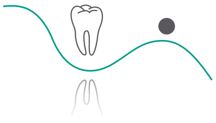


Praxis Dr. Kraft M.Sc.
& Kollegen – Zahnärzte –

Medical history

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.

Your practice team

Personal information

Patient

Surname ______________________ First name ______________________

Date of birth ______________________

Main insurant

Surname ______________________ First name ______________________

Date of birth ______________________

Street/no. ______________________ Post code/city ______________________

Phone no. ______________________ Mobile phone ______________________

E-mail ______________________

Health insurance ______________________

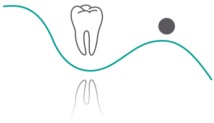
Profession ______________________ Employer ______________________

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 Zahnarzte» - 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 ______________________



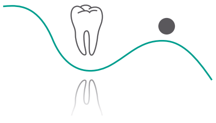
Praxis Dr. Kraft M.Sc.
& Kollegen – Zahnärzte –

Medical history

Medical treatment:	Are you currently being treated for a medical condition? If yes, what condition?	yes	no
General practitioner/ medical specialist:	Name, address and phone number of your general practitioner/medical specialist:		
Medikamente:	Please list current regular medication:		
Allergies:	Is there a possible hypersensitivity to any materials or medications? 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? If yes, where?	yes	no
Pregnancy:	If yes, how many months pregnant are you?		

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

Date ______________________________ Signature ______________________________



Praxis Dr. Kraft M.Sc.
& Kollegen – Zahnärzte –

Servicebogen

Dear patient,
We are continuously working on making your stay at our practice as pleasant as possible. For this purpose, we would like to get to know you better and understand what matters to you. This is what the following questions are for.
We are grateful for your help!

Patient

Surname ______________________ First name ______________________

Where did you find out about us?

Google   homepage of our practice   review site: which one? ______________________

personal recommendation: by whom? ______________________

other: ______________________

May we remind you of your regular check-ups?

yes   no

Do you wish to receive information about our practice (news, special offers or a newsletter) by email?

yes   no

How happy are you with your teeth in general?

very happy   happy   unhappy   not sure

How happy are you with the colour of your teeth?

very happy   happy   unhappy   not sure

How happy are you with the position of your teeth?

very happy   happy   unhappy   not sure

What topics do you wish us to advise you on?

bleaching   tooth correction   veneers   implants

Date ______________________ Signature ______________________