VOGEL & NITZSCHKE

ZAHNÄRZTE

PATIENT CONTACT INFORMATION FORM:

General health issues can have an impact on your dental treatment. Because of that, we ask you to fill out this questionnaire in as much detail as possible. It's of great importance for your safety that you tell us everything. Please note that we treat all data as strictly confidential. We may save your data electronically, but will treat it with the strictest confidentiality to protect your privacy.

PATIENT:

Surname, First name _____ Date of birth _____

Street #/ Appt # _____ Postal/zip code _____ City _____

Primary Telephone # _____ Day Time Telephone # _____

Insurance _____ Occupation _____

Surname, First name of primary policy holder (If different from above) _____ Date of birth _____

Alternate Street, No. (If applicable) _____ Postal/zip code _____ City _____

		YES	NO
Are you currently undergoing medical treatment?			
Heart/circulatory diseases	Weak heart (cardiac insufficiency)		
	Cardiac arrhythmia/irregularity		
	Pacemaker		
	Heart valve defect/replacement		
	Endocarditis		
	Heart surgery		
	Circulatory disturbances of the coronary arteries		
	Heart attack/stroke … when?		
	Hypertension		
Blood	Anaemia		
	Tendency for thrombosis		
	Blood coagulation deficiency / prolonged bleeding		
Rheumatism diseases			
Infectious diseases	HIV-infection/AIDS		
	Hepatitis/Jaundice A ☐ B ☐ C ☐ D ☐		
	Tuberculosis (TBC)		
	Other:		
Other	Neurological diseases		
	Epilepsy		
	Lung diseases: Difficulty in breathing/asthma/mucoviscidosis		
	Eye diseases (glaucoma?)		
	Diabetes		
	Osteoporosis		
	Thyroid malfunction		
	Immune diseases		
	gastric- / intestinal / kidney diseases		

Please turn the page

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		JA	NEIN
Surgeries in the head-/ neck area?			
Why and when?			
Other, not previously mentioned diseases:			
Allergies/Intolerances	Hay fever / eczema		
	Antibiotics (if so, which?)		
	Other reactions to medication:		
	Existing allergy ID		
Are you taking any meications? If so, which?			
Are you pregnant? If yes, how many weeks?:			

Reason for your visit:

☐ Check up/consultation
☐ Toothache/emergency treatment
☐ bleeding gums
☐ bruxism/tooth grinding
☐ halitosis
☐ other:

Consulting requests:

☐ Professional tooth cleaning/whitening
☐ Amalgam-alternatives/amalgam removal
☐ Ceramic fillings
☐ „smile-make over"/cosmetic dentistry
☐ Implants

Your comfort is important to us. Please indicate if you have any of the following:

☐ anxiety
☐ severe gag reflex
☐ very sensitive teeth
☐ What did you miss at your previous visits to the dentist?

☐ How did you come to know of us?

Please note: In order to serve you better, we ask that any appointments needing to be cancelled or changed, are done so with a minimum of 24 hours notice. Emergency cases excepted.

Date Signature

Thanks for your information!