MEDICAL HISTORY QUESTIONNAIRE

Zahnkultur Berlin

Zahnkultur Berlin • ÜBAG Öztan & Partner

Welcome to Zahnkultur Berlin!

We are pleased to welcome you as a patient. First we would like to ask you to carefully fill out this questionnaire.
In this way we will obtain important information which may possibly have an effect on your dental treatment.

We also require certain data for a smooth administrative procedure as well as for patient services subject to approval. Of course, all information is subject to medical confidentiality and the valid data protection regulations.

Patient

Name | First name

Street, No. | Postal code, location

Date of birth | Telephone number

E-mail

Payer (if not the patient himself/herself, for example parent or legal guardian)

Name | First name

Street, No. | Postal code, location

Date of birth | Telephone number

E-mail

Insurance

Name of cost carrier (health insurance or insurance company)

☐ I am privately insured ☐ I have private supplementary insurance ☐ I have standard rate insurance pursuant to § 25 Para. 2a (SGB V)

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BERLIN-KARLSHORST

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+49 (0)30 500 123 30

Did you or do you have one of the following diseases?

- ☐ Asthma (severe shortness of breath)
- ☐ Diabetes
- ☐ Rheumatism
- ☐ Blood diseases
- ☐ Blood clotting disorders
- ☐ HIV infection
- ☐ Tuberculosis
- ☐ Liver diseases
- ☐ Hepatitis A/B/C (jaundice)
- ☐ Seizure disorder (epilepsy)
- ☐ Thyroid diseases

If applicable, since when? _____

- ☐ No

Allergic reactions to / intolerance of medications or materials

☐ Yes ☐ No

If yes, which? _____

Heart attack

☐ Yes, when? _____ ☐ No

Do you take anticuagulants like Marcumar or Xarelto?

☐ Yes ☐ No

Stroke

☐ Yes, when? _____ ☐ No

Paralyses

☐ Yes, since when? _____ ☐ No

How high is your blood pressure?

☐ Low ☐ Normal ☐ High

Do you have a pacemaker?

☐ Yes ☐ No

Do you regularly take medications?

☐ Yes ☐ No

If yes, which? _____

Are you pregnant?

☐ Yes, week of pregnancy: _____ ☐ No

Do you smoke?

☐ Yes, number per day: _____ ☐ No

Other information or diseases?

_____

Do you attach importance to local anaesthesia?

☐ Yes ☐ No

Do you have an X-ray record?

☐ Yes ☐ No

Are you interested in a prophylaxis programme?

☐ Yes ☐ No

Do you have a bonus booklet?

☐ Yes ☐ No

Would you like an appointment reminder?

☐ Yes ☐ No

I agree that I will be reminded of my appointment per post or SMS (recall system). **

☐ Yes ☐ No

How did you find out about us? (voluntary information)

- ☐ Recommendation of family/friends
- ☐ Google (or other search engine)
- ☐ Residential area (practice signage)
- ☐ Advertising (posters, flyers, etc.)
- ☐ Facebook
- ☐ Jameda
- ☐ Something else, namely: _____

Berlin, _____

Date/signature of patient or legal guardian
(With my signature I confirm the completeness and correctness of my details mentioned above.)

_____

Date/signature
** I agree that I will be entered in the recall system and will be reminded of my appointment per post or per SMS!