PATIENT HEALTH HISTORY FORM

DEAR PATIENT,

please complete this form for our documentation, so it will be possible for us to adapt our dental treatment to your health. Of course all of this is subject to medical confidentiality and data protection.

PERSONAL DETAILS

name | surname | date of birth

street | postcode/residence

phone | mobile phone number | business phone number (voluntary statement)

e-mail (voluntary statement)

INSURANCE

health insurance

☐ statutory health insurance ☐ no health insurance at all ☐ private health insurance

Please fill in, if patient and member of health insurance are not identical.

name | surname | date of birth

street | postalcode/residence

Do you have a Bonusheft? ☐ yes ☐ no

HOW DO YOU GET TO KNOW ABOUT OUR DENTAL OFFICE?

☐ patient of Zahnarztpraxis Schäfer ☐ Internet/Google ☐ Other

☐ personal recommendation of:

name | surname

ZAHNÄRZTE**SCHÖRK**
Gregor Schörk | Zahnarzt
Sandra Schörk | Zahnärztin
Wilhelmstraße 13
71139 Ehningen
Tel 07034 - 5331
Fax 07034 - 60717
mail@zahnaerzte-schoerk.de
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HEALTH STATEMENT

family doctor/pediatrician

medical office/address

	yes	no
high blood pressure	☐	☐
low blood pressure	☐	☐
Do you have any heart diseases?	☐	☐
☐ Heart valve defect/ heart valve prosthesis		
☐ Pacemaker		
☐ Heart attack/Stent		
☐ Endocarditis		
☐ Other		
Bleeding disorders	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Disease of the thyroid gland	☐	☐
Disease of the kidney or anomalies	☐	☐
Rheumatic diseases	☐	☐
Chronic respiratory diseases	☐	☐
Asthma	☐	☐
Osteoporosis	☐	☐
Epilepsy	☐	☐
	☐	☐

Do you have any allergies?

If so, which one?

Do you have an allergy pass? ☐ ☐

Do you have any other diseases? ☐ ☐

If so, which one?

	yes	no
Do you have any infectious diseases?	☐	☐
☐ HIV		
☐ Hepatitis		
☐ MRSA		
☐ Creutzfeld Jakob illness		
☐ Tuberculosis		
☐ Other		
Do you take any medicine regularly?	☐	☐

If so, which one?

☐ Antidepressants

☐ Blood thinning medications

☐ Bisphosphonate

Do you smoke?	☐	☐
If so, how many cigarettes per day?		
Are you pregnant?	☐	☐
If so, in which week?		
Are you getting medical treatment at moment?	☐	☐

If so, why?

When was your last X-ray examination?

Date

Which part of your body has been X-rayed?

PREVENTION

Shall we remind you of your next check-up? ☐ yes ☐ no

If so, how should we remind you? ☐ e-mail ☐ post ☐ phone

Are you interested in a professional teeth cleaning? ☐ yes ☐ no

Special note: Our dental office is working with the Deutsche Zahnärtliche Rechenzentrum (DZR).

We are a dental office in which we see our patients only on appointment, that means we take us special time just for you. And because of this it is important for us, that you cancel your appointment at least 24h previously, so we get a chance to offer these appointments to other patients. With this signature you confirm that all your personal data and health details are right and that you agree to the storage of your data.

place/date | signature

1. update | signature

2. update | signature

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