PERSONAL INFORMATION

Last name/name: _____ Date of birth: _____

Address: _____ Postcode/Town: _____

Tel (Home): _____ Tel (Mobile): _____

Tel (Work): _____ E-Mail: _____

Profession / Employer: _____

Health Insurance: _____

O Public Health Insurance □ Membership □ Co-insured / □ with additional insurance □ without additional insurance

O Private Insurance

Co-insured with the membership of:

Last Name / Name: _____ Date of birth: _____

Address: _____ Postcode/Town: _____

BRIEF MEDICAL HISTORY

Are you currently under any medical treatment? O Yes O No

If yes, for: _____

Name of doctor: _____

Are you currently taking any medication? O Yes O No

If yes, which: _____

Are you allergic to any medication, foods or materials? O Yes O No

If yes, which one/s: _____

Do you suffer / Have you suffered from any of the following conditions? If yes, please check.

O Rheumatism O Liver disease O Tuberculosis O Cardiovascular disease

O Epilepsy O Asthma O Diabetes O Covid-19 (SARS-CoV-2)

Others: _____

Do you have / Have you had any infectious diseases (Hepatitis, HIV, etc.)? O Yes O No

If yes, which one/s: _____

For female patients: Are you pregnant? O Yes (expected due date: _____) O No

How would you rate your sleep? O Good O Average O Bad

Do you smoke? O Yes O No

If yes:

How long have you been smoking for? For _____ years

How many cigarettes do you smoke on average per day? _____ cigarettes

Date: _____ Signature Patient: _____

MEDICAL HISTORY

Surname, name: _____ Date of birth: _____

Name/Address of your main physician and their specialty: _____

How would you rate your overall health? O Excellent O Good O Average O Bad

In the course of dental treatment, it is very important to be well informed about the health of our patients. We therefore kindly ask you to read through and fill out the following questionnaire. Thank you!

DO YOU HAVE or HAVE YOU EVER HAD …? (Please tick and fill in as appropriate.)

ALLERGIES/INTOLERANCES
O Aspirin
O Penicillin
O Erythromycin
O Tetracycline
O Sulfa
O Local anesthetic
O Iodine
O Nickel
O Latex
O Chlorhexidine (CHX)
O Others:

_____

CARDIOVASCULAR SYSTEM
O Bypass O Stent O Pacemaker
(When? _____)
O Condition after heart attack
O Congestive heart failure / heart insufficiency
O History of infectious endocarditis
O Artificial heart valve / repaired defect (PFO)
O Angina Pectoris
O Cardiac arrhythmia
O High blood pressure
O Low blood pressure

HAEMATOPOIETIC ORGANS / VESSELS
O Circulatory Disorder
O Coagulopathy / clotting disorder
O Stroke
O Thrombosis / embolism
O Anaemia
O Prolonged bleeding after small cuts
(INR > 3,5)

RESPIRATORY TRACT / LUNGS
O Asthma
O Chronic bronchitis
O Pneumonia, sarcoidosis, emphysema
O Sleep apnoea
O Snoring

LIVER
O Jaundice
O Hepatitis (Type: ___)

DIGESTIVE SYSTEM
O Digestive problems
(e.g. heartburn, acid reflux, coeliac disease)
O Gastric or duodenal ulcer
O Inflammatory bowel disease
(e.g. Crohn's disease, colitis)
O Eating disorder (e.g. bulimia, anorexia)

METABOLISM / ENDOCRINE SYSTEM
O Hypothyroidism
O Hashimoto
O Hyperthyroidism
O Calcium deficiency
O Parathyroid disease
O Diabetes mellitus (Type: _____)
O High cholesterol level

GENITO-URINARY SYSTEM
O Dialysis
O Kidney disease

MUSCULOSKELETAL SYSTEM
O Rheumatism
O Rheumatoid arthritis
O Gout
O Intervertebral disc problems
O Head or neck injuries
O Osteoporosis, osteopenia
O Joint replacement
(if yes, which one/s and when:

_____)

NERVOUS SYSTEM
O Epilepsy, seizures
O Paralysis
O Depression
O Anxiety
O Headaches / migraines

EYES
O Cataract
O Glaucoma
O Highly impaired vision

OTHERS
O Viral disease (e.g. herpes, HIV/Aids, etc.)
O Lumps or swelling in the oral area
O Autoimmune disease
(e.g. lupus, scleroderma)
O Tumour disease (which: _____)
O Chemotherapy / radiotherapy
O Mental illness
(which: _____)
O Are you currently pregnant?
(if yes, how many weeks? _____)

O Other illnesses or disabilities:

_____

List of medication, supplements and vitamins taken within the last 2 years:
O Anticoagulants
(e.g. aspirin, ASS, marcumar, clopidogrel)
O Heart/Bloodpressure medic. O Cortisone
O Thyroid medication O Bisphosphonates
O Pain medication O Antidiabetics
O Physcotropic drugs O Contraceptives

List of medication (Please attach a full list, if you have one! Thank you.):

_____
_____
_____
_____
_____

Describe any medical treatment or impending surgeries that might possibly affect your dental treatment (e.g. Botox, collagen inj., etc.):

_____

PLEASE INFORM US IMMEDIATLY OF ANY CHANGES IN YOUR MEDICAL HISTORY (INCL. MEDICATION).

Place, Date: _____ Signature patient /Legal guardian: _____

Signature treating dentist: _____

DENTAL HISTORY

Referred by: _____

Previous Dentist: _____ How long were you a patient there? _____ Months/Years

How would you rate your overall dental condition? O Excellent O Good O Average O Bad

Date of the most recent dental exam: _____ Date of the most recent X-rays: _____

Date of the most recent dental treatment (other than cleaning): _____

I routinely see my dentist every: O 3 Months O 6 Months O 12 Months O Unregularly

What is your immediate concern? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH YES OR NO:	YES	NO
PERSONAL HISTORY		
1 Are you scared of dental treatment? How scared are you on a scale from 1 (not at all) to 10 (extremely) = (___)	O	O
2 Have you had any unfavorable dental experiences?	O	O
3 Have you ever had complications from previous dental treatment?	O	O
4 Have you ever had any issues with ineffective local anesthetics or reactions to local anesthetic?	O	O
5 Did you ever have braces, orthodontic treatment or your bite adjusted? If yes, at what age? (Age: ___)	O	O
6 Have you ever had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	O	O
GUM AND BONE		
7 Do your gums bleed sometimes or are they ever sore after brushing or flossing?	O	O
8 Have you ever been treated for gum disease, had scaling and root planing or been told you have lost bone around your teeth?	O	O
9 Have you ever noticed an unpleasant taste or odor in your mouth?	O	O
10 Is there anyone with a history of periodontal disease in your family?	O	O
11 Have you ever experienced any gum recession or can you see the roots of your teeth?	O	O
12 Have you ever had any teeth become loose on their own (not due to an injury) or do you have difficulties eating an apple?	O	O
13 Have you experienced any burning or painful sensations in your mouth not related to your teeth?	O	O
TOOTH STRUCTURE		
14 Have you had any cavities within the past 3 years?	O	O
15 Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	O	O
16 Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	O	O
17 Are any teeth sensitive to heat, cold, biting, sweets or do you avoid brushing any parts of your mouth?	O	O
18 Do you have grooves or notches on your teeth near the gum line?	O	O
19 Have you ever had any broken teeth, chipped teeth or had a toothache or cracked filling?	O	O
20 Does food frequently get caught between your teeth?	O	O
BITE AND JAW JOINT		
21 Do you have any issues with your jaw joint? (pain, sounds, limited opening, locking, popping)	O	O
22 Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	O	O
23 Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguette, protein bars or other hard, dry foods?	O	O
24 Have your teeth changed in the past 5 years (have they become shorter, thinner or worn) or has your bite changed?	O	O
25 Are your teeth becoming more crooked, crowded or overlapped?	O	O
26 Have your teeth been developing spaces or are they becoming more loose?	O	O
27 Do you have trouble finding your bite or do you feel the need to squeeze or tap your teeth together or shift your jaw to make your teeth fit together properly?	O	O
28 Do you place your tongue between your teeth or do you close your teeth against your tongue?	O	O
29 Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	O	O
30 Do you clench or grind your teeth during the day?	O	O
31 Do you have any problems with sleep (e.g. restlessness or teeth grinding)? Do you ever wake up with a headache or sensitive teeth?	O	O
32 Do you wear or have you ever worn a bite appliance?	O	O
APPEARANCE / AESTHETICS		
33 Is there anything that you don't like about your teeth/smile?	O	O
34 Have you ever bleached (whitened) your teeth?	O	O
35 Have you felt uncomfortable or self-conscious about the appearance of your teeth?	O	O
36 Have you been disappointed with the appearance of previous dental work?	O	O

Kompetenzteam für Zahnheilkunde
KONZEPT.KOMPETENZ.QUALITÄT.SERVICE

Datenschutzrechtliche Einwilligungserklärung

für die Verarbeitung personenbezogener Patientendaten
gemäß Art. 6 Abs. 1 Buchst. a), Art. 7 DSGVO

Patient/in:

Name _____

Straße _____

PLZ, Ort _____

Ich stimme hiermit der Speicherung meiner personenbezogenen Daten für folgende Zwecke zu:

- die Verarbeitung von Gesundheitsdaten von Patienten zum Zweck der Erfüllung gesetzlicher Dokumentationspflichten
- die Verarbeitung und Weitergabe (auch telefonisch, per Email oder Fax) von Patientendaten zur Planung und Durchführung von Behandlungen z.B. an Anästhesisten, Chirurgen, Zahntechniker, o. Ä.
- die Verarbeitung von Patientendaten zum Zweck der Erstellung einer Abrechnung
- die Verarbeitung von Patientendaten zur Forderungsdurchsetzung
- die Verarbeitung von Patientendaten im Zusammenhang mit einem Recall–System

Ich bin darauf hingewiesen worden, dass ich diese Zustimmung jederzeit schriftlich oder durch E–Mail an die Praxis widerrufen kann (Art. 7 Abs. 3 DSGVO).

Mir ist bekannt, dass mein jederzeit möglicher Widerruf der Einwilligung die Rechtmäßigkeit der aufgrund der Einwilligung bis zum Widerruf erfolgten Verarbeitung nicht berührt (Art. 7 Abs. 3 Satz 2 DSGVO).

_____ _____

Ort, Datum Unterschrift des Patienten / des gesetzl. Vertreters