

Name, Surname		Date of birth (day-month-year)
Address		
Home Phone	Mobile	E-Mail
Occupation		Dental insurance company
How did you learn of us?		Supplemental insurance YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>1. What is the reason for your dental appointment?</b>		
<input type="checkbox"/> check up	<input type="checkbox"/> pain	<input type="checkbox"/> loose teeth
<input type="checkbox"/> gum bleeding	<input type="checkbox"/> recessions	<input type="checkbox"/> other:
<b>2. When was your last X-ray examination performed?</b>		
<b>3. Have you ever had a prophylaxis (dental cleaning)?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	
<b>4. Do you want to have more information about teeth bleaching?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	
<b>5. Are you currently under medical care?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	If yes, please describe:
<b>6. Are you currently taking medication?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	If yes, please describe:
<b>7. Do you have any allergies?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	<input type="checkbox"/> hay fever <input type="checkbox"/> asthma <input type="checkbox"/> skin rash <input type="checkbox"/> food allergy <input type="checkbox"/> pain killer <input type="checkbox"/> local anaesthetic <input type="checkbox"/> medicine (e.g. Penicillin, Aspirin) <input type="checkbox"/> plaster <input type="checkbox"/> latex <input type="checkbox"/> other:
<b>8. Did you ever have a reaction to injections (e.g. local anaesthetic), medication or materials?</b>		
No <input type="radio"/>	Yes <input type="radio"/> If yes, please describe:	
<b>9. Do you have a blood disorder such as hemophilia?</b>		
No <input type="radio"/>	Yes <input type="radio"/>	

Over please



**10. Do your wounds heal normally?**

No      Yes  
     

**11. Have you ever suffered from any heart conditions?**

No      Yes       high/ low blood pressure       endocarditis       heart attack       angina pectoris  
             cardiac anomaly       other:

**12. Do you have a cardiac pacemaker or artificial heart valves?**

No      Yes  
     

**13. Do you have any of the following?**

No      Yes       thyroid disease       tuberculosis       HIV/ AIDS       rheumatism, arthritis  
             glaucoma       epilepsy       kidney disease/ artificial kidney       hepatitis  
 other:

**14. Are you diabetic? Do you take insulin?**

No      Yes  
     

**15. Do you smoke?**

No      Yes  
     

**16. Are you suffering from any other disease not listed?**

No      Yes  
     

**17. Women: Are you pregnant?**

No      Yes  
     

The time has been reserved for you.  
Unless 24 HOURS NOTICE is given for cancellation, a fee may be charged.

Berlin, date

Signature of patient or legal guardian