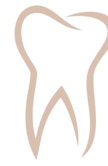
Personal Medical/Dental History
(please fill in completely)



DIE OLDENBURGER ZAHNÄRZTE
Gemeinschaftspraxis für Zahnheilkunde

Preferred salutation: ☐ Mrs. ☐ Mr. ☐ __________

Surname, First name | Date of birth | City of birth

Street, House number | Postcode, Place

Phone (landline/mobile) | Phone (business)

Email* | Occupation* | Place of employment* *optional

Name of health insurance

☐ Public health insurance ☐ Private insurance ☐ basic plan ☐ no basic plan ☐ Eligible for benefit ☐ Supplementary insurance ☐ Voluntarily insured

Is there a primary healthcare level? ☐ no ☐ yes level of care: ____________________

Referring general practice or dental practice – Name, Address, Phone

General practice – Name, Address, Phone

How did you find out about our practice?

☐ Internet ☐ Facebook ☐ Instagram ☐ Recommendation ☐ Newspaper ☐ Jameda ☐ Referral ☐ emergency service

If the person to be treated and the person liable to pay are not the same, please add the following information:
Preferred salutation: ☐ Mrs. ☐ Mr. ☐ __________

Surname, First name (person liable to pay) | Date of birth

Street, House number | Postcode, place

Occupation* | Place of employment* *optional

Letter of acceptance in the treatment of minors:

If the patient has not yet reached the age of 18, they are eligible for treatment only (except acute pain treatment) as in the consent of the legal guardian:

Date | Signature of legal guardian

Is there supervision according to §1896 – 1980i Civil Code: ☐ yes ☐ no

Does a Care Degree exist? ☐ yes Care Degree: ______ ☐ no

Cardiovascular disease:

High blood pressure	☐ yes	☐ no
Low blood pressure	☐ yes	☐ no
Heart valve disease-/defect	☐ yes	☐ no
Heart surgery (date: __________)	☐ yes	☐ no
Pacemaker	☐ yes	☐ no

Other: ______________________

Allergies/intolerances:

Local anesthetics	☐ yes	☐ no
Medication	☐ yes	☐ no
Antibiotics	☐ yes	☐ no
Allergy pass	☐ yes	☐ no

Other: ______________________

Where you operated in the last 6 month? If yes, details of operations: ______________________

Infectious diseases

HIV	☐ yes	☐ no
Hepatitis (A, B, C, D)	☐ yes	☐ no
Tuberkulosis	☐ yes	☐ no

Other: ______________________

Blood:

Anemia	☐ yes	☐ no
Bleeding tendency	☐ yes	☐ no

Other: ______________________

Lungs:

Asthma/Chronic bronchitis	☐ yes	☐ no
Tuberkulosis	☐ yes	☐ no

Other: ______________________

Nervous system:

Seizure disorder	☐ yes	☐ no
Depressionen	☐ yes	☐ no
Rheumatic diseases	☐ yes	☐ no

Other: ______________________

Metabolism:

Diabetes	☐ yes	☐ no
Thyroid disorders	☐ yes	☐ no
Kidney disease	☐ yes	☐ no

Other: ______________________

Other:

Cancers	☐ yes	☐ no
Osteoporosis	☐ yes	☐ no

Other: ______________________

General information:

Drug consumption	☐ yes	☐ no	if yes, which: ______________________
Alcohol consumption	☐ yes	☐ no	if yes: ☐ rare ☐ often ☐ regularly
Smoker	☐ yes	☐ no	if yes: ☐ 0 – 10 ☐ more than 10 cigarettes a day
Regular medication	☐ yes	☐ no	if yes, since when __________ drug name: __________
Do you take bisphosphonates?	☐ yes	☐ no	
Previous X-ray examinations	☐ yes	☐ no	
Pregnancy	☐ yes	☐ no	

Important information:

- All information is subject to medical confidentiality and the provisions of data protection in accordance with Art. 9 Para. 2 GDPR and is therefore treated as strictly confidential.
- I agree that the practice collects, processes and uses my personal and health-related data for the purpose of diagnostics, treatment and billing. The practice may also transmit my personal and health data to third parties in so far as this is necessary for treatment and billing. I was given the detailed declaration of consent. I have read and understood them.
- I undertake to inform you immediately of any changes that occur during the treatment period.
- Our practice is managed according to the ordering system, which means that the time agreed with me is reserved exclusively for me. I undertake to keep agreed appointments or to cancel them at least 48 hours in advance. Otherwise I will bear the costs amounting to 50% of the fee, unless I am not at fault for the omission.
- I confirm with my signature that I have read and understood the printed information.

☐ I agree that the Email address I have provided can be used for the purpose of reminding me of an appointment and for communicating medical or organizational information.

Date	Signature of person to be treated	Signature payable or legal guardian