zahnarztpraxis
Dipl.-stom. Astrid Görlitz

Case History

We are pleased to welcome you to our surgery. To be able to give you the best possible treatment we need some information about yourself and your health status. General illnesses can also have an impact on your dental health and require various treatment options. All information given is subject to medical confidentiality and data privacy requirements and will be handled strictly confidential.

Personal data

Name / Surname

Date of birth

Street/ number

Postal code / City

Phone-No. private

Phone-No. work

E-Mail

Profession / Employer

Insurance

Health insurance

statutory health insurance ❑ yes ❑ no

additional insurance ❑ yes ❑ no

private insurance ❑ yes ❑ no

entitled to aid ❑ yes ❑ no

Base rate ❑ yes ❑ no

If you are not insured by yourself, please give the informationof the insurance holder.

Name / Surname

Date of birth

Street/ number

Postal code / City

Place and date of issue

Signature patient / Payer

Place and date of issue

Signature patient / Payer

Place and date of issue

Signature patient / Payer

Please turn round!

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General health situation

Have you ever suffered from

High blood pressure	❑ yes	❑ no
Low blood pressure	❑ yes	❑ no
Blood clotting dysfunction	❑ yes	❑ no
Heart diseases	❑ yes	❑ no
If so, which one: _____		
Stroke	❑ yes	❑ no
Diabetes	❑ yes	❑ no
HbA1c value: _____		
Gum bleeding	❑ yes	❑ no
Tinnitus	❑ yes	❑ no
Epilepsy	❑ yes	❑ no
Glaukoma	❑ yes	❑ no
Thyroid disease	❑ yes	❑ no
Rheumatism	❑ yes	❑ no
Tuberculosis	❑ yes	❑ no
HIV	❑ yes	❑ no
Hospital germ MRSA	❑ yes	❑ no
Osteoporosis	❑ yes	❑ no
Hepatitis	❑ yes	❑ no
If so, which type? ❑ A ❑ B ❑ C		
Allergies	❑ yes	❑ no
If so, against what? _____		
Other illnesses		

Which medication are you taking

- ❑ Cardiovascular drugs
- ❑ Analgesics
- ❑ Blood-thinning medications
- ❑ Antidepressants
- ❑ Cortison
- ❑ Bisphosphonate
- ❑ Other medications: _____

Have you ever suffered from an intolerance to drugs or injections? ❑ yes ❑ no

If so, against which? _____

Do you carry

a pacemaker	❑ yes	❑ no
a defibrillator	❑ yes	❑ no

A question to our female patients

Are you pregnant?	❑ yes	❑ no
If so, in which week? _____		

Do you have a X-ray passport? ❑ yes ❑ no

Are you a smoker? ❑ yes ❑ no

How many cigarettes per day? ❑ <10 ❑ ≥10

Are you under supervision? ❑ yes ❑ no

Dental health

What can we do for you

❑ Medical check-up ❑ Consultation ❑ Pain management ❑ New dentures ❑ Referral ❑ Second opinion

❑ Others: _____

How satisfied are you with the positioning of your teeth?	❑ ja	❑ nein
Do you grind your teeth?	❑ ja	❑ nein
Do you have problems with your gum? (Bleedings, gum recession)	❑ ja	❑ nein
Are you suffering from chronic bad breath or bad taste in your mouth ?	❑ ja	❑ nein
Have your teeth been checked regularly?	❑ ja	❑ nein
Have your teeth been cleaned professionally?	❑ ja	❑ nein