PRAXIS FÜR ZAHNHEILKUNDE
Dr. med. dent. Markus Gottinger

Dr. med. dent.
Markus Gottinger

We would like to welcome you to our Dental Practice and would be grateful if you could take a few minutes to answer the following questions:

Patient Name: _____ Surname: _____ Date of Birth: _____

Person Insured Name: _____ Surname: _____ Date of Birth: _____

Correspondence Address

Postal code: _____ City: _____

Street: _____ House number: _____

Telephone private: _____ Mobile: _____

Email: _____

Occupation: _____ Employer: _____

Telephone at work: _____ Address: _____

Name of Medical Insurer: _____

☐ State ☐ Private

☐ Voluntary state insurance ☐ Assisted

☐ Private additional insurance

Family Doctor's Name : _____

Please turnover

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Please answer the following questions about your health. Tick the box to indicate if you currently suffer or have ever suffered from any of the conditions listed below. If yes, please give further details:

	No	Yes	
Heart, circulatory disorders?	☐	☐	Which? _____
Diabetes?	☐	☐	Type?_____
Infectious diseases? (e.g. Hepatitis, TB, HIV)	☐	☐	Which? _____
Allergies?	☐	☐	Which? _____
Disorders of the Nervous system? (e.g. Epilepsy)	☐	☐	Which? _____
Thyroid problems?	☐	☐	Which? _____
Asthma?	☐	☐	
Tumours?	☐	☐	Which? _____
Other illnesses?	☐	☐	Which? _____
Are you taking medication? (e.g. anticoagulants, sedatives, bisphosphonates)	☐	☐	Which? _____
Are you pregnant?	☐	☐	
Do you have artificial dentition?	☐	☐	Since when? _____
When was your last visit to the dentist?			_____
When was your last oral X-ray?			_____
How did you hear about this practice?			_____

Advice: Please be assured that your information will be treated with the strictest confidence. Following an injection your motor skills may be temporarily affected, so we advise that you refrain from driving. If there are any changes to this information we would be grateful if you could update us.

Would you like to participate in our 6-monthly recall system? ☐ Yes ☐ No

if so: ☐ by email ☐ by postal mail

Our practice is based on an appointment system. We would appreciate your punctuality and that you cancel your appointment 24 hours in advance if necessary, otherwise we will be obliged to charge a no-show fee.

Starnberg, date _____ Signature: _____