

Medical history sheet

Dear Patient,

Welcome to the Dormagen Dental Centre! To help us get to know your health condition and your special needs, please answer the following questions. If you have any questions, please feel free to ask our reception staff. We will be pleased to assist you. Thank you in advance for your efforts and understanding.

Personal details

Surname, first name	Date of birth
Street and house number	Postcode and city
Landline and mobile phone number (number at which we can best reach you during the day)	Place of birth
Health insurance fund	You have come by recommendation of:
Insured person (in the case of persons not insured directly)	Occupation
Birthday (of the insured person)	Do you have a supplementary dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

Our services

Regular reminders

- I would like to use the dental centre's recall service. Please regularly remind me of my next appointment for a checkup and/or treatment by letter or by e-mail. I can revoke my participation in the recall at any time.

How would you like us to remind you?

- By letter By e-mail

(e-mail address the notification is to be sent to)

Declaration of consent

I agree to the transfer of the treatment data, findings and X-ray images required for my treatment by other doctors to these upon request, also by e-mail. I also agree that the Dormagen Dental Centre may, if necessary, request X-ray images from other doctors. I know that I may revoke this consent in full or in part at any time.

Contact details of previous dentist

Dormagen,

Place and Date

Signature of the patient

Health issues

Do you suffer from high blood pressure? Yes No

Do you suffer from low blood pressure? Yes No

Have you ever had any heart surgery? Yes No

If so, tick as appropriate:

Bypass surgery Yes No

Artificial heart valve Yes No

Pacemaker Yes No

Other (please specify)

Are you a regular drug user? Yes No

Do you suffer from alcohol abuse problems? Yes No

Do you smoke? Yes No

Do you regularly take any medication? Yes No

If so, which?

Do you have any drug intolerance? Yes No

If so, which?

Do you have any allergies? Yes No

If so, which?

Do you suffer from any of the following?

Diabetes Yes No

Asthma/lung disease Yes No

Hepatitis (A/B/C)/liver disease Yes No

Seizures (e.g. epilepsy) Yes No

Glaucoma (increased pressure in the eye) Yes No

Immune deficiency (HIV) Yes No

Hypothyroidism Yes No

Hyperthyroidism Yes No

Do you have any other ailments? Yes No

If so, which?

Are you pregnant? Yes No

If so, which week?

Are you very afraid of the dental treatment? Yes No

Do you have any artificial joints? (e.g. hip, knee or other joint) Yes No

If so, when did you undergo the surgery? (month and year)

Information about local anaesthesia in dentistry

Dentists use local anaesthesia to provide pain relief in the mouth, teeth, jaw and face. Though local anaesthesia are a safe way of preventing pain, side effects and intolerance to the substances used cannot be ruled out. Moreover, the following complications can occur:

Haematoma, difficulties opening the mouth, nerve damage, permanent numbing, impairment of responsiveness and concentration, cardiovascular problems, altered perception of taste, hypersensitivity reactions (allergies)

The impaired function is typically fully restored.

Legal agreement

- All information is subject to medical confidentiality and data protection provisions and is therefore treated as strictly confidential. I agree to the storage of my personal data.
- I undertake to inform you promptly of any changes that arise during the treatment period.
- I undertake to comply with appointments made or to cancel them by

phone at least two days in advance. Otherwise, we reserve the right to charge you for any costs incurred.

- **With my signature, I confirm that I have read and understood the printed explanations and information. Furthermore, I confirm that the all details I have provided are accurate.**

Dormagen, den

Place and date

Signature of the patient