DOMANIECKI DENTAL CENTER

IHRE ZAHNÄRZTE

Registration | Medical History

Dear Patient (m/f/d),

Thank you for coming to our practice for treatment. We operate on an appointment system, which typically means minimal waiting times for you. However, unforeseen medical interventions may occasionally cause delays, and appointments might not always be adhered to exactly. We ask for your understanding in these situations. If you cannot keep an appointment we've scheduled, please cancel it as early as possible, i.e., at least 24 hours in advance. If you come to our practice due to unforeseen emergencies (e.g., acute pain), please expect waiting times.

If you are a patient (m/f/d) with statutory health insurance, it is imperative that you present your health insurance card no later than 10 days after the start of treatment. Otherwise, you will be billed privately for the treatment costs. As a patient (m/f/d) insured under the statutory scheme, you have the option of treatment through your health insurance card or private billing in accordance with § 13 SGB V (cost reimbursement).

Patient

first name | surname | date of birth

Address

Street / House Number | E-Mail | Place of Birth

Postal Code / City | Phone Number | Mobile Phone Number

Member / Payer
(Legal Guardian)

first name | surname | date of birth

Address

Street / House Number | E-Mail | Place of Birth

Postal Code / City | Phone Number | Mobile Phone Number

Payer
(health insurance)

- ☐ I am compulsorily insured.
- ☐ I am voluntarily insured.
- ☐ I am entitled to a subsidy
- ☐ I have a private suppl. insurance
- ☐ I am privately insured
- ☐ I am insured under the standard tariff
- ☐ I am insured under the basic tariff
- ☐ I have chosen the cost reimbursement according to §13 SGB V
- ☐ I am not insured
- ☐ I am eligible for a subsidy (social welfare office, compensation office)

Occupation of the member

Employer

☐ Pupil / Student

Employer's address

Street / House Number | Postal Code / City | Phone number

Patient's occupation

Employer

☐ Pupil / Student

Employer's address

Street / House Number | Postal Code / City | Phone number

Please see back!

For your medical record, we request the following information, which is subject to medical confidentiality and data protection, and will be treated with the utmost confidentiality by us. Please also inform our practice of any future changes in your health condition, your address, and your insurance status!

1. Have you ever had or do you currently have any of the following diseases?

a)

	yes	no		yes	no		yes	no
Asthma	☐	☐	Hematologic disorders	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Coagulation disorders	☐	☐	Renal dysfunction	☐	☐
Rheumatic disease	☐	☐	Hospital superbug MRSA	☐	☐	Creutzfeldt-Jakob	☐	☐
Osteoporosis	☐	☐	Liver diseases	☐	☐	Tumor/Carcinoma/Cancer	☐	☐
Tuberculosis	☐	☐	Hepatitis A/B/C	☐	☐	Are you taking/have you taken bisphosphonates in this context?	☐	☐
HIV-Infection	☐	☐	Epilepsy	☐	☐			

Your primary care physician

Name	Address	Phone number

b) Any known allergies? ☐ yes ☐ no — if yes, which ones?

Do you have an allergy card? ☐ yes ☐ no

c) Heart attack ☐ yes ☐ no

Stroke ☐ yes ☐ no

Paralysis ☐ yes ☐ no

Are you taking blood thinners? ☐ yes ☐ no — if yes, which ones?

c) blood pressure ☐ low ☐ normal ☐ high — if applicable, values

2. Do you have a pacemaker? ☐ yes ☐ no

3. Do you take medication regularly? ☐ yes ☐ no — if yes, which ones?

4. Do you smoke? ☐ yes ☐ no

5. Do you snore? ☐ yes ☐ no

6. Are there any addiction disorders? ☐ yes ☐ no — if yes, which ones?

7. Is there a pregnancy? ☐ yes ☐ no ☐ unknown — if yes, how many weeks?:

8. Was there or has there been an injury in the mouth, jaw, or facial area? ☐ yes ☐ no — accident date / type of injury

9. Additional information / other medical conditions

10. Do you prefer treatment under local anesthesia if needed? ☐ yes ☐ no

Please note that driving ability may be impaired for several hours under the influence of medication or local anesthesia injections.

11. Do you have an X-ray record? ☐ yes ☐ no

Would you like to have an X-ray record? ☐ yes ☐ no

When was your last X-ray/CT scan? (Date/Body part)

12. Do you have a bonus booklet? ☐ yes ☐ no

When was your last professional dental cleaning performed?

13. Do you have dental supplementary insurance? ☐ yes ☐ no

14. How did you become aware of our practice? ☐ Rec. ☐ Internet ☐ Newspaper ☐ signs on the building ☐ other

With my signature, I confirm the completeness and accuracy of the information provided above and expressly consent to the processing of my personal data in the practice.

Date

Signature of patient or legal guardian