MEINE ZAHNÄRZTE
ZAHN+ZENTRUM

ANAMNESIS / QUESTIONNAIRE

(Please fill out in printed letters)

GENERAL INFORMATION

Surname* _____ Name* _____ Date of Birth* _____

Member Surname* _____ Name* _____ Date of Birth* _____

Street / No.* _____

Post / Zip Code* _____ City* _____

Phone* _____ Mobile _____ Business _____

E-Mail * _____

Country & City of of Birth* (§28 Röntgenverordnung) _____

Nationality _____

Occupation _____ Employer _____

Public Insurance * _____ ☐ Additional Insurance ☐ Voluntary

Private Insurance* _____ ***Mandatory fields**

GENERAL HEALTH RECORD

	yes	no
Medicine allergies (e.g. Penicillin)	☐	☐
Other allergies	☐	☐
If yes, which ones? _____		
Heart disease	☐	☐
Blood pressure ☐ high ☐ low		
Coagulation disorder	☐	☐
Asthma / Chronic bronchitis	☐	☐
Angle-closure glaucoma (Eye disease)	☐	☐
Thyroid disease	☐	☐
Diabetes (Sugar disease)	☐	☐
Kidney / liver disease	☐	☐
Epilepsy (Cramping seizure)	☐	☐
Psychological disease (therapy)	☐	☐
Osteoporosis	☐	☐
Tumour	☐	☐
Taking of Bisphosphonaten	☐	☐
Infections e.g. Hepatitis	☐	☐
Tuberculosis	☐	☐
HIV	☐	☐
Do you take any medicine regularly?	☐	☐
If, yes which ones? _____		
Any other diseases? _____		
Do you smoke?	☐	☐
If yes, how many? _____		

DENTAL HEALTH RECORD

Which matter brings you to our practice?

_____

_____

_____

	yes	no
Bleeding / Shrinkage of the gums	☐	☐
Sounds of the mandibular joint (e.g. while chewing)	☐	☐
Pain in the neck / on the head	☐	☐
Do you have a dental prosthesis / implant?	☐	☐
If yes, for how many years? _____		
Did you have an orthodontic treatment in the past?	☐	☐
Are you satisfied / happy with your teeth's colour / form / position: i.e. are you happy with your smile?	☐	☐
Are you interested in an especially intensive treatment for caries and shrinkage of the gums?	☐	☐
Did you ever have a professional tooth cleaning (i.e. prophylaxes)	☐	☐
If yes, when? _____		

PLEASE TURN THE PAGE!
FURTHER FIELDS ON THE BACKPAGE!

MEINE ZAHNÄRZTE ZMVZ GmbH

GESCHÄFTSFÜHRER:
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HRB 15501

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STEUER-NR.: 003 239 46063

MEINE ZAHNÄRZTE
ZAHN ZENTRUM

When was the last time you got a dental x-ray? _____ month ago.

Dentist _____

Address _____

For female patients:

Are you pregnant?

☐ Yes, in the _____ week.
☐ No
☐ Uncertain

We kindly ask you to inform us immediately, if you get pregnant during the treatment period.

My special wishes / request for the dentist

_____

_____

Whom do we have to thank that you consulted our practice?

_____

How did you notice our practice? (e.g. Internet ads, Facebook, Google, posters etc.)

_____

IMPORTANT:

We want to inform you that your driving ability might be limited after local anaesthesia.
Further we kindly ask you to inform us as soon as your medical conditions changes.

All information is subject to medical confidentiality and data protection. Your data is stored in our in-house data processing. Disclosure to third parties (X-ray images to your dentist, patient data for treatment in sedation or data for the external laboratory to examine histological material) is made with your consent. Patient privacy information is available at the reception and on our homepage: www.meine-zahnaerzte.de.

Since we offer our patients fixed appointments, we kindly ask you to cancel agreed appointments 48 hours in advance. By that you would do us and the other patients a favour. If repeated non-appearance without cancelation occurs, we might be unable to give you fixed appointments due to organizational reasons. Further non-appearance can be charged according to §§615 BGB, 275 ZPO.

Permission to terminate by phone or e-mail

yes ☐ no ☐

I confirm the knowledge, my agreement and the accuracy of the information.

Date, Place_____ Signature _____