

**Praxisklinik der Zahnheilkunde am Luisenhospital
Dr.med.dent. Martin Emmerich und Partner**

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Welcome to our surgery!
To take care of you in an optimal way,
we need some information:

Sheet of registration with medical history:

Name: _____ if your not member of you health
Insurance, who is the insured?
First name: _____ name: _____
Date of birth: _____ first name: _____
Address: _____ date of birth: _____
Phone private: _____ Cell phone: _____
E - mail: _____ @ _____
Profession: _____ Who should get the invoice?
Employer: _____ name: _____
address: _____
Phone at job: _____
Health insurance: _____ Are you abetment entitled from
Compulsorily insured? Yes No civil service? Yes No
Do you have an additional insurance for dental treatment? Yes No
How do you want to be reminded for your next prevention appointment?

by phone

1. Weekday: _____ from: _____ to: _____
2. Weekday: _____ from: _____ to: _____
3. Weekday: _____ from: _____ to: _____

by mail

We request you, in case of not keeping your appointment, to cancel at the latest 24 hours
before your appointment. Otherwise the costs caused by your absence could be brought to
account. (according to §615 BGB)

signature

city, date

Our patient's individual needs are taken very serious.
Would you kindly let us know,
what should be considered especially?

Afraid of dental intervention: Yes No
Intensive pain-sensitivity: Yes No
Intensive choke impulse: Yes No

What did you miss the most by visiting your Dentist?

Due to whom or what did you point out our surgery?

On the recommendation of acquaintance: name: _____
Referral by dentist: name: _____
Referral by general practitioner: name: _____
Internet:

Do you have any advisory wishes:

Periodontal diseases: Yes No
Implant accommodations: Yes No
Treatment under general Anaesthesia Yes No
Amalgam removal: Yes No
Dental-coloured fillings: Yes No
Intensive cleaning of teeth: Yes No
Bleaching of teeth: Yes No
Dental aesthetics / cosmetics / your smile: Yes No
Miscellaneous: _____
Are you interested in continuous prevention
to avoid new diseases? Yes No

Cause of your visitation

Please answer the following questions in your personal interest.
All details are treated by patient confidentiality.

Normal check - up: Yes No
Pain: Yes No
If yes, since when do you have pain: Yes No
Where are your ailments: _____
Do you have any gum bleedings? _____
Are your teeth loosened? Yes No
Referral due to Periodontal treatment: Yes No
Referral due to implant treatment: Yes No
Do you have any pain at jaw joint: Yes No
Do you have headache or pain at your neck? Yes No
Do you press or creak your teeth? Yes No
Referral due to jaw-joint ailments? Yes No

Actual or previous Diseases:

Osteoporosis: Yes No
Epilepsy: Yes No
Lung disease / asthma: Yes No
Blood thinning medicaments (aspirin, marcumar etc.) Yes No
Diabetes: Yes No
Clotting annoyance: Yes No
Artificial cardiac valve / pacemaker: Yes No

Cardiac insufficiency / heart disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cardiac infarction / stroke:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High blood pressure:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Low blood pressure:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Liver Disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hepatitis B / C:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
HIV positive / immune disease?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Gastrointestinal disease / Kidney disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatism:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Thyroid disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Migraine:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Glaucoma:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Prostate disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Any allergies on medicaments / matters ? Yes No
 If yes, which: _____
 Do you have an allergy pass? _____

Do you smoke? Yes No
 If yes, how many cigarettes per day? _____

Are you pregnant? Yes No
 If yes, week of pregnancy? _____

Have you been x-rayed? Yes No
 Last x-ray: _____
 Taken by: _____

General:

There are different payment options in our surgery:
 The invoice is sent to you by our business office "EOS" Yes No
 The invoice is paid directly after treatment cash or by
 EC - cash with 2 % cash-discount Yes No
 (Please pay individual amounts to 100, - € directly after the treatment)

Our surgery offers only highest quality and there is no difference between compulsory and private insured patients. So there is a co-payment for compulsory insured patients for dental coloured fillings to the amount of 50-75 € per tooth, for radix-treatment to the amount of 60 € per radix.

I approve I answered the best of the knowledge.

first/surname city, date