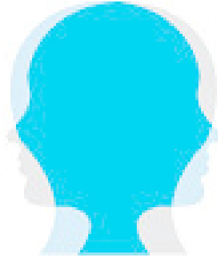

Praxisklinik der Zahnheilkunde am Luisenhospital
Dr. med. dent. Martin Emmerich und Partner

Boxgraben 99 - 52064 Aachen
Telefon: 0241 - 4007277 - Telefax: 0241 - 4007278

Herzlich willkommen in unserer Praxis!
Um Sie optimal betreuen zu können,
benötigen wir einige Daten von Ihnen.

Anmeldebogen mit Anamnese 22. Juli 2019

Name:

First name:

Date of birth:

Birthh Place (Important for inormation X register entry)
____

Adress: ______________________

____

phone private: ______________________

E-Mail: ___________________________________@_________________________

profession: ______________________

Employer: ______________________

____

Phone at job: ______________________

Health insurance : ______________________
Compulsorily insuredt: YES (_) / NO(_)

if your not member of you health
Insurance, who is the insured?

Name: ______________________________

First name: ___________________________

Date of birth: ______________________

Cell phonel: _________________________

Who should get the invoice?

Name: ______________________________

Adress: ____________________________

Are you abetment entitled from
civil service? YES (_) / NO (_)

Do you have an additional insurance for dental treatment? YES (_) / NO (_)
If yes, please bring a copy of your additional insurance policy.

How do you want to be reminded for you r next prevention appointment?

(_) by mail (_) by SMS

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).

____

Aachen, 22. Juli 2019

We take our patients´ individual needs seriously
Kindly let us know, if we should especially consider:

Fear of dental intervention: YES (_) / NO (_)
Heightened pain-sensitivity: YES (_) / NO (_)
Heightened choke impulse: YES (_) / NO (_)

What did you miss the most when visiting your previous Dentist?

____

How did you find out about our surgery?
Friend´s recommendation: name:_________________
Referral by Dentist: name:_________________
Referral by General Practitioner: name:_________________
Internet / web sites: name:_________________

Do you have any special requests?
Periodontal diseases: YES (_) / NO (_)
Implants: YES (_) / NO (_)
Amalgam removal: YES (_) / NO (_)
Dental-colored 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 regular preemptive treatment? YES (_) / NO (_)

Reason of your visit

Please answer the following questions with your best interest in mind.
All information given remains strictly confidential.

Normal check - up: : YES (_) / NO (_)
Suffering from pain: YES (_) / NO (_)
If yes, since when do you have pain: __________________________________?
Where are your ailments: ____?
Do you have any gum bleedings? YES (_) / NO (_)
Are your teeth loose? YES (_) / NO (_)
Referral due to Periodontal treatment? YES (_) / NO (_)
Referral due to implant treatment: YES (_) / NO (_)
Do you have any pain at the jaw joint: YES (_) / NO (_)
Do you have a headache, or pain in your neck? YES (_) / NO (_)
Do you grind or squeak your teeth? YES (_) / NO (_)
Referral due to jaw-joint ailments? YES (_) / NO (_)

Medical history
Actual and/or previous diseases

Osteoporosis? YES (_) / NO (_)
Epilepsy? YES (_) / NO (_)
Lung disease / asthma? YES (_) / NO (_)
Blood thinning medication (aspirin, marcumar etc.) ? YES (_) / NO (_)
Diabetes? YES (_) / NO (_)
Clotting annoyance? YES (_) / NO (_)

Artificial cardiac valve / pacemaker?	YES (_) / NO (_)
Cardiac insufficiency / heart disease?	YES (_) / NO (_)
Cardiac infarction / stroke?	YES (_) / NO (_)
High blood pressure?	YES (_) / NO (_)
Low blood pressure?	YES (_) / NO (_)
Liver Disease?	YES (_) / NO (_)
Hepatitis B / C ?	YES (_) / NO (_)
HIV positive / immune disease?	YES (_) / NO (_)
Gastrointestinal disease / Kidney disease?	YES (_) / NO (_)
Rheumatism?	YES (_) / NO (_)
Thyroid disease?	YES (_) / NO (_)
Migraine?	YES (_) / NO (_)
Have you ever treated for cancer?	YES (_) / NO (_)
Glaucoma:	YES (_) / NO (_)
Prostate disease:	YES (_) / NO (_)

Are you allergic to medication and/or substances ? YES (_) / NO (_)
If yes, which: ____
Do you have an allergy pass? YES (_) / NO (_)

Are you taking any medicines? YES (_) / NO (_)
If yes, which: ____

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: _________________________

Please tell us a prefered time for your appointment:
Mo Tue Wed Thu Fri Sat

Please tell us your favourite time for a recall:
Mo Tue Wed Thu Fri Sa

Where are you reachable?
Telephone:
Mobilephone:
E-Mail:
Professional:
other Things:

We kindly ask you to send us current and/or existing dental x-rays before your appointment.

General Terms

Costs of up to _150,- to be paid directly after the treatment

Our surgery offers only the highest quality treatment and there is no difference in service for mandatory or privately insured patients. There is an excess for mandatory patients e.g. for colored dental fillings of _60-_90 per tooth.

I here with confirm, that I have given all information to the best of my knowledge,

Aachen, den 22. Juli 2019 ______________________________