ANAMNESIS

ZAHNMEDIZIN AM IMMERBACH

Dear patient!

To offer you the best medical care, we need some information concerning your health. Please fill out this form completely and inform us about changes in the future All data given are of course subject of our medical confidentiality.

Persönliches:

Last and first name: _____ date of birth: _____ in: _____

Street / No.: _____ Tel. during daytime _____

Zip code and city: _____ E-Mail: _____

Medical insurance company: _____ ▫ statutory ▫ additional insurance
▫ private ▫ eligible for benefit

If you are not insured yourself, who is the member of the medical insurance?

Name: _____ date of birth: _____

Street / No.: _____ Zip code and city: _____

Who is your family doctor?

Name: _____ Tel. no. _____

Street / No.: _____ Zip code and city: _____

Organizational:

Our practice has a booking system. Your appointment is exclusively reserved for you. If you are not able to keep your appointment, please call off at least 48 hours before. For nonappearance or short term cancellation, a fee will be charged.

For our statistics only:

How did you find us?

▫ recommendation ▫ telephone book ▫ newspaper advertisement

▫ internet, which page _____ ▫ other: _____

Did you visit our website (http://www.DrKroonder.de) prior to your appointment?
▫ yes ▫ no

Would you like to join our recall-system?
▫ yes ⟶ ▫ by phone ▫ by E-Mail
▫ no

Do you have or did you ever have a disease concerning…

heart / circulation system	▫ yes	▫ no	liver	▫ yes	▫ no
kidneys	▫ yes	▫ no	thyroid gland	▫ yes	▫ no
stomack / intestines	▫ yes	▫ no	joints (rheumatism)	▫ yes	▫ no
spinal column	▫ yes	▫ no	nervous system	▫ yes	▫ no

Have you ever had…

high blood pressure	▫ yes	▫ no	low blood pressure	▫ yes	▫ no
diabetes	▫ yes	▫ no	bleeding gums	▫ yes	▫ no
ear whiz / tinnitus	▫ yes	▫ no	epilepsy	▫ yes	▫ no
glaucoma	▫ yes	▫ no	asthma	▫ yes	▫ no
blood coagulation disorders	▫ yes	▫ no	cystic fibrosis	▫ yes	▫ no
tuberculosis	▫ yes	▫ no	allergies	▫ yes	▫ no
MRSA-infection	▫ yes	▫ no	if yes, against what :		
HIV / Aids	▫ yes	▫ no	_____		
Hepatitis	▫ yes	▫ no			
if yes, which type	▫ A	▫ B ▫ C	_____		

other: _____

Do you smoke ▫ no ▫ yes

Concerning your heart. Do you have or did you ever have…

▫ an infection of the heart valves ▫ angina pectoris ▫ a bypass
▫ a pacemaker ▫ a stent ▫ a cardiac infarction

Medication? Are you taking regularly…

▫ heart medication ▫ cortisone (corticoids) ▫ analgesics (e.g. Aspirin®)
▫ antidepressants ▫ blood thinning medication (e.g. Marcumar®, ASS)

▫ Other regularly taken medication: _____

Have you ever experienced an intolerance against medication or injections? ▫ no ▫ yes

if yes, against what: _____

For our female patients:

Are you pregnant? ▫ no ▫ yes: Please tell us the week of pregnancy: _____

Questions / comments: _____

_____
Date / signature (minors – please signature of the legal guardian)

Thank you very much for your cooperation!
The team of your dental practise