FELGNER
PRAXIS FÜR ZAHNERHALTUNG

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completly as you can.
It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. If you have questions we'll be glad to help you.

PATIENT

Last Name | First Name

Date of Birth | Country and City of Birth

INSURANCE OWNER

Last Name | First Name

Date of Birth

ADDRESS

Street | Phone

Zip / City | Email Address*

PROFESSION

HEALTH-INSURANCE

☐ European Health Insurance Card ☐ Secondary Dental Insurance

REFERRAL INFORMATION*

☐ Dentist Referral ☐ Family & Friends ☐ Internet/ Social Media

WHAT IS THE REASON FOR YOUR DENTAL VISIT TODAY?

☐ Regular Exam ☐ Second opinion ☐ Unhappy with the appearance of my teeth
☐ Pain ☐ Referral

APPOINTMENT REMINDERS

We offer you the option of regular reminders of upcoming follow-up appointments free of charge and without obligation.

Please contact me via: ☐ E-mail ☐ Phone

Date _____ Signature of Patient / Legal Guardian _____

CONSENT TO THE PROCESSING OF PERSONAL DATA

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. A copy of our privacy policy can be obtained from pur website or from reception. Fields marked with an asterisk (*) are optional to fill in.

Date _____ Signature of Patient / Legal Guardian _____

CONTINUED ON BACK →

MEDICAL HISTORY

MEDICAL INFORMATION

Are you under the care of a physician? Yes No

If yes, please specify:

PHYSICIAN (Name / Address / Phone)

MEDICATION

Are you currently taking any prescription or over-the-counter medications? Yes No

Please list all medications you are taking:

ALLERGIES

Penicillin or other antibiotics	Yes	No
Pain-relievers	Yes	No
Iodine	Yes	No
Latex (rubber)	Yes	No
other		

CARDIOVASCOLAR DISEASES

High blood pressure	Yes	No
Low blood pressure	Yes	No
Cardiac arrhythmias	Yes	No
Congestive heart failure	Yes	No
Damaged heart valves	Yes	No
Pacemaker	Yes	No
Previous infective endocarditis	Yes	No
Heart attack / stroke	Yes	No
Ocular hypertension / glaucoma	Yes	No

CANCER / CHEMOTHERAPY

If yes, please specify: Yes No

METABOLIC DISEASES

Diabetes Type I or II	Yes	No
Thyroid disease	Yes	No
Gastrointestinal disease	Yes	No
Osteoporosis	Yes	No
Other?		

BLOOD DISEASES

Bleeding problems?	Yes	No
Anemia	Yes	No
Are you taking blood thinners?	Yes	No
If yes, please specify:		

NEUROLOGICAL DISORDERS

Epilepsy	Yes	No
Seizures	Yes	No

INFECTIOUS DISEASES

Hepatitis (A/B/C)	Yes	No
HIV infection	Yes	No
Tuberculosis	Yes	No

RESPIRATORY DISEASES

Asthma	Yes	No
COPD	Yes	No
Do you smoke?	Yes	No
If yes, how much do you typically smoke?		

WOMEN ONLY

Are you pregnant?	Yes	No
Number of weeks?		

DENTAL X-RAY

Did you have an x-ray taken within the last two years? Yes No

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE? Yes No

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my helath ord medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent or legal guardian) to the Dental Office Dr. Felgner.

Date

Signature of Patient / Legal Guardian