ZAHNARZTPRAXIS AM MARKT
Und ich fühl mich blendend.

Bernhard Pitzer | Dentist
Am Markt 21
D - 69123 Heidelberg
Phone +49 (0)6221.77 51 50
Fax +49 (0)6221.77 51 80
info@zapam.de

Dear Patient,

a warm welcome to the Zahnarztpraxis Am Markt. We are always about to offer you the best possible dental treatment. As you know, dentistry is overlapping with other medical disciplines. Therefore, it is needful for your own security to fill in the following form completely and as accurately as possible. This information is subject to medical privacy and data protection laws. It will be handled with strict confidentiality and be added to your patient file. The 'Information on collection of personal data' is available in our practice.

Please do not hesitate to ask us, if you need any assistance in filling in this form - thank you for your confidence!

Personal Data

..... First Name - Last Name (Patient)

..... Date of Birth

..... Street Name - House Number

..... Postal Code - City

..... Phone (Home)

..... Mobile Phone

..... E-Mail

..... Occupation

..... Health Insurance

- ❍ I am insured in the basic tariff („Basistarif" §12 VAG)
- ❍ I am beneficiary of the public service
- ❍ I have a private supplementary dental insurance

In case the owner of your insurance is someone else than you, please tell us the following details about this person:

..... First Name - Last Name (Payor)

..... Date of Birth

..... Street Name - House Number

..... Postal Code - City

Persons under the age of 18 need the consent of their parent(s) to be treated (except for the treatment of acute pain)

..... Place - Date

..... Signature of Parent(s)

Continued on back →

Patient Questionnaire

Please answer the following questions about your state of health as accurately as possible:

Heart/Cardiovascular diseases

High blood pressure	❍ yes / ❍ no
Heart valve disease	❍ yes / ❍ no
Blood coagulation disorder	❍ yes / ❍ no
Low blood pressure	❍ yes / ❍ no
Pacemaker	❍ yes / ❍ no

Other diseases: .....

Infectious diseases

HIV/AIDS	❍ yes / ❍ no
Tuberculosis	❍ yes / ❍ no
Hepatitis	❍ A ❍ B or ❍ C / ❍ no

Other infectious diseases: .....

Allergies / Intolerances

Hay fever	❍ yes / ❍ no
Pain medication	❍ yes / ❍ no
Antibiotics	❍ yes / ❍ no
Local anaesthesia/injections	❍ yes / ❍ no

Others: .....

Do you own an allergy passport? ❍ yes / ❍ no

Other Diseases

Asthma / Lung diseases	❍ yes / ❍ no
Thyroid disease	❍ yes / ❍ no
Gastro-intestinal disease	❍ yes / ❍ no
Kidney diseases	❍ yes / ❍ no
Migraine	❍ yes / ❍ no
Rheumatism/arthritis	❍ yes / ❍ no
Epilepsy	❍ yes / ❍ no
Diabetes	❍ yes / ❍ no
Fainting spells	❍ yes / ❍ no
Tinnitus	❍ yes / ❍ no
Glaucoma	❍ yes / ❍ no
Artificial joint replacement	❍ yes / ❍ no

Others: .....

General Information

Are you pregnant? ❍ yes / ❍ no
If yes, what week/month? .....

Do you smoke? ❍ yes / ❍ no
If yes, how many cigarettes per day? .....

Which medication do you take regularly or are you currently taking?

.....

.....

Have you had x-rays? ❍ yes / ❍ no
If yes, when? .....
Are you currently under any medical treatment? ❍ yes / ❍ no

Who is your family doctor?

.....
Name and Address

Why do you seek dental treatment?

Do you have a toothache?	❍ yes / ❍ no
Do you have bleeding gums?	❍ yes / ❍ no
Is your gum retracting?	❍ yes / ❍ no
Do you have loose teeth?	❍ yes / ❍ no
Do you have any crackling or pain in the jaw joint?	❍ yes / ❍ no

Others: .....

How did you find out about us?

.....

I want to take part in the **Recall System**. Please inform me about regular dental check-ups or necessary medical treatments. ❍ yes / ❍ no

This consent can be withdrawn at any time.

Important Information

I agree to immediately report any and all changes arising during the treatment period. I further agree to keep all scheduled treatment appointments or to cancel them **at least 24 hours prior** to the scheduled appointment. I understand that appointments not cancelled in time will be billed.
I hereby authorise the electronic storage, processing and use of my data, also for the Recall System. All information is subject to medical confidentiality and data protection laws.
By signing this form, I declare that all the statements I have made are to the best of my knowledge correct and complete and that I have read the information.

....
Place - Date Signature Patient/Payor/Parent(s)

Zahnarztpraxis Am Markt | Bernhard Pitzer | Dentist | Am Markt 21 | D - 69123 Heidelberg | Phone +49 (0)6221.77 51 50