PATIENT QUESTIONNAIRE

for our NEW patients

Dear patients,

we are pleased to welcome you in our office. But we need your help to make your visit as pleasant as possible. To fulfill your wishes in the best possible way, we ask you to fill in this questionnaire carefully. General illnesses can also affect the dental treatment. All information is of course subject to medical confidentiality. Also read our privacy information on our website or in our waiting room of our office. Also read our privacy information on our website or in our waiting room of our office.

Yours, Dr. Ralf Voßler & Team

(Pat.-Nr._____)

Personal data

Surname | First name of the patient | Date of birth | Nationality

Street | Zip code, City | Country

Phone number - private and /or at work | Mobile number

E-Mail | Profession | Employer

Health plan / insurance / sickness fund, in which you - patient - are insured

Do you have an additional insurance? yes ○ no ○

Are you privately insured in Germany? yes ○ no ○

If patient (for example, children) and member of the insurance are not identical, complete the data of the policyholder, please:

Surname | First name of the patient | Date of birth | Nationality

Street, zip code, city and country, if different from above

Name of your family doctor

How did you become aware of our office?

Personal recommendation: ○ Others: _____

Oral health situation

	yes	no
Do you crunch or clench with your teeth?	○	○
Do you have gum problems?	○	○
E.g. bleeding while brushing your teeth	○	○
Or receding gums?	○	○
Do you suffer from bad breath?	○	○
Do you suffer from a bad taste in the mouth?	○	○
Are you UNsatisfied with the position, color and shape of your teeth?	○	○

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General health situation

Do you suffer from

	Yes	no		Yes	no
High blood pressure	○	○	Low blood pressure	○	○
Blood cuagulation disorder	○	○	Thyroid disease	○	○
Rheumatic disease	○	○	Tumor disease	○	○
Asthma	○	○	Are you smoking?	○	○
Kidney diseases	○	○	Do you have artificial joints?	○	○
Infectious diseases like: HIV	○	○	Tuberculosis	○	○
Hepatitis	○	○	if so, which: _____		
Diabetes	○	○	if so, which type: _____		
Allergies	○	○	if so, which: _____		
Cardiovascular disease	○	○	if so, which: _____		
Have you had an apoplectic stroke?	○	○	if so, when: _____		
Are you taking any medicines?	○	○	if so, which: _____		
Is this an Antibiotic?	○	○	Bisphosphonate?	○	○
Pain killer?	○	○	Blood thinning drug?	○	○
Antidepressants?	○	○	Cortisone?	○	○
Do you have other diseases?	○	○	if so, which: _____		
Did you have previous operations?	○	○	if so, which: _____		
Did you tolerate dental anesthesias well?				○	○
Only for our female patients: Are you pregnant?				○	○
Do you have a current bonus book?				○	○
Up to now, have your teeth been professionally cleaned twice a year / annually?				○	○
Do you desire an appointment reminder?				○	○

If so by: E-Mail ○ Mail ○ Mobile / Phone ○

Do you have a special request for us?

_____

We offer the service of an order office. That means for you, that the time is reserved for you at your appointment. Therefore, we ask you to cancel your appointments in good time, but at least 24 hours in advance. This gives us the opportunity to offer other patients your agreed time. In this way, a longer waiting time can be avoided.

With my signature I confirm the correctness of the above mentioned health information, have taken note of the privacy policy and agree with the processing of my personal data in the sense of the privacy policy for patients (see announcement).

Date: _____ Signature: _____.

intern information - noted _____.

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