Evaluation form about general existing disease

Many general disease are able to effect the dental-medical treatment. Therefore we ask you to fill out this evaluation form. Please note the information provided is included within the medical oath and the requirement of confidentiality. We only collect these information for our dental treatment and to respond on your health. The information might be stored electronically if necessary. We do of course respect the strict regulations of privacy data protection.

patient: _____
name first name birthday

insured one: _____
name first name birthday health insurance

☐ compulsorily ☐ voluntary insurance ☐ privately insured: _____

address : _____
postal code place street phone number privat/ mobile phone number office.

e mail: _____ employer*: _____ job*: _____
* voluntary

name and address of her family doctor: _____

What kind of disease do you have / did you have?		Please, fill or mark yes	no
heart illnesses:	heart weakness (insufficiency) ……..…….....	☐	☐
	abnormal heart rhythm (arrhythmia) ……..…….....	☐	☐
	heart asthma / anginapectoris ……..…….....	☐	☐
	pacemaker …….....	☐	☐
circulatory illnesses:	too high blood pressure …….....	☐	☐
	too low blood pressure …….....	☐	☐
	heart attack, when?_____……	☐	☐
	taking of coagulation-restraining drugs , anticoagulant…….....	☐	☐
	fainting fits……..…….....	☐	☐
metabolism illnesses :	Diabetes ……..…….....	☐	☐
	gastrointestinal disease……..…….....	☐	☐
	thyroid gland disease…..…….....	☐	☐
illnesses of nerv system:	epileptic attacks / cramps ….....……..…….....	☐	☐
blood illnesses	bleeding inclination (haemophilia).....	☐	☐
	anaemia.....……..……	☐	☐
allergies:	eczemas ……..…….	☐	☐
	asthma ……..…….	☐	☐
	Penicillin-hypersensitivity ……..…….....	☐	☐
	Do you own an allergy ID? ……..…….....	☐	☐
	over-sensitive against _____	☐	☐
infection illnesses:	hepatitis A or B / jaundice.....……..…….....	☐	☐
	tuberculosis ……..……	☐	☐
	Chronic illnesses of the respiratory tract cough etc.…..……..……	☐	☐
	AIDS, HIV ……..……	☐	☐
Immunsystem disorder?	Do you suffer from illnesses of your immun-system? If so what kind? _____	☐	☐
Which drugs / medication are you taking momentarely?	_____		
Do you take drugs against bone-metabolism-disturbance as for example osteoporosis (bisphosphonate) or have you taken these in the past?		☐	☐
Forther information:	Are you pregnant? Which month? ….....…….	☐	☐
	Are you or were you addicted to drugs? ….....…….....	☐	☐
	Are you newly operated ?…….....	☐	☐
	When were you X-rayed for the last time? _____	☐	☐
	Do you own / want a X-ray ID?..…….……	☐	☐
	Which care products do you use for your dental care?_____ _____	☐	☐

Thank you for providing the information. **date: _____** **sign: _____**

NIEMEYER NEUBAUER
ZAHNÄRZTE

Dear patient,

Thank you for trusting us with the health of your teeth. So that we can better respond to your wishes and problems, we would ask you to answer the following questions or tick the appropriate boxes. Thank you very much!

1. My last visit to the dentist was on _____

2. Today I come because of:

- ▫ Toothache
- ▫ Bleeding / inflammation of the gums
- ▫ because I have problems with my dentures / prosthesis.
- ▫ I am not happy with the color / shape / position of my teeth
- ▫ I am interested in bleaching.
- ▫ Other reasons _____

3. I became aware of the practice by:

- ▫ Family, friends, acquaintances
- ▫ Internet portals, search engines _____
- ▫ other doctors, dentists _____

4. ▫ I am interested in information on dental care (prophylaxis).

- ▫ I would like to be reminded regularly of my preventive appointment. (recall)
- ▫ To maintain my teeth, I would accept private services that are not covered by the statutory health insurance companies (AOK, DAK etc.) are covered. We will inform you in advance about the costs.

Please also inform us immediately of any changes in your health status (new illnesses, changes in medication, etc.).

I agree that before extensive treatments, information may be obtained from EURO-PRO Gesellschaft für Data Processing mbH or similar providers. providers regarding my creditworthiness. This information is subject to confidentiality and will of course be treated as strictly confidential.

Our practice is organized according to an appointment system. For you, this means short waiting times and undisturbed treatment time, during which we can take optimum care of your problems. We therefore ask you to cancel appointments that you cannot keep at least 24 hours in advance. If you do not keep your appointment, we reserve the right to charge you for the time you have to stay.

A fee of 95,- EUR / 30 minutes of reserved treatment time will be charged.

We have commissioned "Doctolib GmbH" for online appointment management. I agree that necessary data such as name, e-mail, telephone number etc. will be transmitted to this company in strict compliance with the GDPR. You will be notified of agreed appointments by email and/or text message.

I consent to the storage of my necessary data within the framework of the statutory provisions and retention periods.

Potsdam, date _____ Signature _____