PATIENT QUESTIONNAIRE

Dear Patient,
We are delighted to welcome you in our dental office! We are specialised on prophylactic, innovative, prosthetic and aesthetic dentistry. Please speak with us about your wishes and preferences. Our team will be happy to advise you about adequate alternatives and to provide individual solutions.

Before we begin, we kindly require you to complete this form with your personal details as well as general information about your physical condition. This will help us to create a most advantageous and risk-free basis for your dental treatment. All information obtained is subject to professional discretion and dealt with confidentially.

Personal Details

◯ MR ◯ MRS ◯ MS

FIRST NAME & NAME ____________________

DATE OF BIRTH ____________________

ADDRESS ____________________

POSTAL CODE, CITY ____________________

PHONE PRIVATE ____________________

PHONE MOBILE ____________________

PHONE OFFICE ____________________

EMAIL ____________________

OCCUPATION ____________________

EMPLOYER ____________________

Health Insurance

HEALTH INSURANCE PROVIDER ____________________

◯ INSURANCE ON DUTY ◯ PRIVATE INSURANCE
◯ VOLUNTARY INSURANCE ◯ ____________________

Please state the insurance holder, if not insured yourself:

FIRST NAME & NAME ____________________

DATE OF BIRTH ____________________

ADDRESS ____________________

POSTAL CODE, CITY ____________________

General Practitioner

NAME, CITY, PHONE ____________________

Bonusheft

◯ YES
◯ NO

How did you find out about us?

◯ PERSONAL RECOMMENDATION ◯ ADVERTISEMENT ◯ INTERNET ____________________

◯ REFERRAL ____________________ ◯ OTHER ____________________

Frankfurter Straße 13a
61476 Kronberg im Taunus

T +49 (0) 6173 49 32
F +49 (0) 6173 55 75

info@zahnzentrum-kronberg.de
www.zahnzentrum-kronberg.de

PLEASE TURN OVER!

What is the reason for your visit

- ◯ CHECK-UP
- ◯ ACUTE PAIN TREATMENT
- ◯ CONSULTATION
- ◯ GINGIVAL BLEEDING
- ◯ DENTAL REFERRAL ______________________________

When was your last dentist appointment? ________________

How frequently do you visit a dentist? ________________

When was your last x-ray taken? ________________

You are interested in

- ◯ conservative dentistry
- ◯ professional cleaning
- ◯ advice about aesthetic and innovative prosthetic treatment
- ◯ Recall – regular reminders for your next check-up
- ◯ advice about bone preservation and dental implants
- ◯ anti-stress applications for your treatment
- ◯ payment by instalments

Physical Conditions

	IF YES, WHICH?	DOCTOR'S COMMENTS
◯ ALLERGIES (document of sensitizers?)		
◯ ATTACKS (epilepsy, ...)		
◯ INCREASED INTRAOCULAR PRESSURE (glaucoma)		
◯ BLOOD DISEASES		
◯ HEART DISEASES (infarct, pacemaker)		
◯ INFECTIOUS DISEASES (hepatitis, HIV, ...)		
◯ CIRCULATORY DISEASES (blood pressure, ...)		
◯ LIVER DISEASES (hepatitis A/B, ...)		
◯ LUNG DISEASES (asthma, ...)		
◯ GASTROENTEROPATHY		
◯ NEURONAL DISEASES		
◯ RENAL DISEASES		
◯ RHEUMATIC DISEASE /OSTEOPOROSIS		
◯ THYROID DISEASE		
◯ CANCER		
◯ DIABETES		
◯ ADDITIONAL DISEASES		
◯ FORMER OPERATIONS		
◯ DO YOU TEND TO SECONDARY BLEEDING?		
◯ DO YOU CURRENTLY INTAKE ANY MEDICATIONS?		
◯ ARE YOU PREGNANT?	WEEK OF PREGNANCY ______	
◯ DO YOU SMOKE?	QUANTITY / DAY ______	

We thank you for your kind assistance! **Please inform us about any amendments to your details.**
By singing this document, I confirm the completeness and correctness of the information provided on both sides of this form.

______________________ KRONBERG, DATE

______________________ SIGNATURE OF PATIENT OR PARENTS