

Name of the insurance company		
Name, Surname of the insurant		Date of birth
Insurance-No.	Insurant-No.	Status
Doctor-Nr.	Insurance card expiry date	Date



GEMEINSCHAFTSPRAXIS
DR. KARIN BAUM | DR. THOMAS BAUM



Questionnaire

Dear patient,

a warm welcome to our practice. We are always about to offer you the best possible dental treatment. As you know, dentistry is overlapping other medical disciplines. Therefore it is needful to your own security to fill out this form thoroughly and truthfully .

Your personal data is carefully kept secret to the public. They are protected by doctor-patient-confidentiality through german federal law (§ 203 StGB) and the strictly rules of privacy. We handle everything responsible and add this form to your patient-register.

In case you would need our assistance, please do not hesitate to ask us. We are pleased to support you as good as we can!

Name: _____ Surname: _____ Date of birth: _____
 Adress: _____
 Phone-No.: _____ Mobile Phone: _____ Fax: _____ E-Mail: _____
 Profession: _____ Company: _____ Health-Insurance: _____

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

Name: _____ Surname: _____ Date of birth: _____
 Adress: _____

Please mark the following answers by cross and fill the applicable fields.

To arrange our dental treatment in nessesary cases with your **medical practitioner**, please tell us the name and adress of the doctor:

Have you been under **medical treatment** over the past 2 years? yes no
 If yes, for what reason? _____

Are you taking any medicine currently or regulary? yes no
 If yes, which?

Allergies

Is there any known allergie you suffer against materials or medicine? yes no
 If yes, against what?

Do you own a documentation-form about the allergie? yes no

Diseases of the Blood

Bleeding disorder (Hemophilia)? yes no
 Anemia? yes no
 Anything else? _____



Cardiovascular diseases

Cardiac insufficiency? yes no
 Irregular heartbeat (Arrhythmia)? yes no
 Angina pectoris (Stenocardia)? yes no
 Pacemaker? yes no
 Artificial heart valve? yes no
 Heart defect? yes no
 Heart attack? yes no
 High blood pressure? yes no
 Low blood pressure? yes no
 Anything else? _____

Other diseases of the viscera

Gastro-intestinal diseases? yes no
 Renal disease (kidney ailment)? yes no
 Chronic disease of the respiratory tracts? yes no
 Diseases associated with tumors or former tumor-operations? yes no
 If yes, linked to bisphosphonat-therapy? yes no
 Anything else? _____

Infektionen

Icterus (hepatitis)? yes no
 Tuberculosis? yes no
 Have you ever been tested for HIV? yes no
 If yes, what was the result? _____
 Anything else? _____

X-Ray

Have you had dental x-rays within the last 12 months? yes no
 If yes, where was the examination? _____

Your **individual convenience** is important to us! If you have any personal expectation or wishes ahead of the dental treatment, please let us know:

We offer a free **recall service** to inform our patients about the regulary dental check-up. It is without obligation for both sides.
 Do you want us to arrange this service for you? yes no

I assert I filled this questionnaire completely and to the best of my knowledge.

 (Location, Date)

 (Signature)

Sincere thanks to you for your support! We will refresh this form regulary. However, please tell us immediatly about any changes of medical issues!