



ZAHNHEILKUNDE
LINDENTHAL

Surname:

First Name:

Title:

Street, No..

Zip code, City:

Tel. no. private:

work:

mobile:

E-mail-address::

Date of birth:

Occupation:

Employer:

insured:

statutory private entitled to state aid (Beihilfe) supplementary dental insurance

Name of insurance company:

Are you insured through someone else?

Insured Last Name:

First Name:

Date of birth:

Street, No..

Zip code, City:



When is the best time to reach you?

in the morning

in the afternoon

How / through whom did you become attentive of ZAHNHEILKUNDE LINDENTHAL?

What is the best way for us to remind you of your preventive appointment (recall)?

by E-mail

per mail

thank you, I'll think of it myself

If you are unable to keep a scheduled appointment, please cancel it at least 24h in advance. If we do not receive a cancellation from you in due time, we unfortunately have to charge you a cancellation fee for the time reserved for you (§615 sentence 1 BGB). Missed appointments through no fault of your own will of course not be charged. Thank you for your understanding!

Date:

Signature:

With your signature, you confirm the accuracy of your above information and expressly agree to the storage of your personal data. Please inform us immediately of any changes. Please also note that your ability to drive may be impaired for up to 24h after dental treatment. This can be caused by the treatment itself as well as by the influence of injections or other medications. If you wish, we will therefore be happy to call a cab to take you home safely.



Dear patients,

We are very pleased to welcome you to our dental office ZAHNHEILKUNDE LINDENTHAL! In order to make your visit with us as pleasant as possible, we need your support. We therefore ask you to answer the following questions conscientiously, because general illnesses can also have an effect on dental treatment. All information is, of course, subject to medical confidentiality. If you have any questions when filling out the form, we will be happy to help.

Do you suffer (have you suffered) from any diseases of the:

Heart or circulation	<input type="radio"/> yes <input type="radio"/> no
Liver	<input type="radio"/> yes <input type="radio"/> no
Kidneys	<input type="radio"/> yes <input type="radio"/> no
Thyroid	<input type="radio"/> yes <input type="radio"/> no
Gastrointestinal tract	<input type="radio"/> yes <input type="radio"/> no
Joints (rheumatism/arthritis))	<input type="radio"/> yes <input type="radio"/> no

Do you/ Did you have:

High blood pressure	<input type="radio"/> yes <input type="radio"/> no
Low blood pressure	<input type="radio"/> yes <input type="radio"/> no
Pacemaker/valve replacement	<input type="radio"/> yes <input type="radio"/> no
Diabetes	<input type="radio"/> yes Typ <input type="radio"/> no
Tinnitus	<input type="radio"/> yes <input type="radio"/> no
Epilepsy	<input type="radio"/> yes <input type="radio"/> no
Glaucoma/ cataract	<input type="radio"/> yes <input type="radio"/> no



Asthma yes no
Tuberculosis yes no
Osteoporosis yes no
HIV (AIDS) yes no
Hepatitis yes, Typ A B C no

Do you have any allergies?

yes, to _____ no

What medications do you take regularly?

Heart medication Cortisone (corticosteroids)
 Painkillers Antidepressants
 Anticoagulant medications (e.g. Markumar/ ASS) Bisphosphonates
 Other medications _____

Do you have any other diseases?

When was the last time your teeth were x-rayed?

Do you smoke?

yes, _____ cigarettes/ day no



ZAHNHEILKUNDE
LINDENTHAL

For our female patients: Are you expecting a baby? If yes, which week?

Are you afraid of dental treatments?

Date:

Signature:



How would you rate your oral health (teeth and gums)?

very good

good

satisfactory

What do you use for oral hygiene at home?

<input type="radio"/> Manual toothbrush	<input type="radio"/> Soft <input type="radio"/> Medium <input type="radio"/> Hard	<input type="radio"/> Plastic bristles <input type="radio"/> Natural bristles
<input type="radio"/> Electric toothbrush		
<input type="radio"/> Mouthwash (brand)		
<input type="radio"/> Toothpaste (brand)		
<input type="radio"/> Dental floss	<input type="radio"/> Waxed	<input type="radio"/> Unwaxed
<input type="radio"/> Interdental brushes		
<input type="radio"/> Denture cleaner		
<input type="radio"/> Tongue cleaner		
<input type="radio"/> Other		

Are you aware of the benefits of professional tooth cleaning?

yes

no

What is the reason for your visit?

Routine checkup

Pain treatment

Consultation, what topic?

Second opinion

Can you chew and bite without restrictions?

yes no



Do you suffer from hot-cold sensitivity?

yes no

Have your gums ever bled when brushing your teeth or eating?

yes no

Do you have any missing teeth that you would like to have replaced?

yes no

Do you want to replace fillings for health reasons?

yes no

Is your mouth uncomfortably dry sometimes?

yes no

Do you grind or clench your teeth?

yes no

Do you have frequent headaches and neck pain?

yes no

Do you sometimes experience a metallic taste in your mouth?

yes no

Do you snore?

yes no

How do you like your teeth?

very good good satisfactory



Do you wish your teeth would be:

- brighter
- straighter
- more natural in appearance for dentures or fillings.
- more complete: gaps should be closed

Do you occasionally struggle with bad breath?

- yes
- no

Do you drink coffee, black tea, or red wine every day?

- yes
- no

Do you smile and laugh without restriction?

- yes
- no

Thank you very much.
ZAHNHEILKUNDE LINDENTHAL