ZAHNHEILKUNDE
LINDENTHAL

Surname: _____ First Name: _____ Title: _____

Street, No. _____ Zip code, City: _____

Tel. private: _____ work: _____ mobile:

E-mail-adress: _____ 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: _____

Dr. med. dent. Lisa Trippe
Dr. med. dent. Sara Parastar
Dürener Straße 46-48
50931 Köln
T 0221. 430 86 888
F 0221. 430 86 887
info@zahnheilkunde-lindenthal.de
www.zahnheilkunde-lindenthal.de

ZAHNHEILKUNDE
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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.

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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	○yes ○no
Liver	○yes ○no
Kidneys	○yes ○no
Thyroid	○yes ○no
Gastrointestinal tract	○yes ○no
Joints (rheumatism/arthritis))	○yes ○no

Do you/ Did you have:

High blood pressure	○yes ○no
Low blood pressure	○yes ○no
Pacemaker/valve replacement	○yes ○no
Diabetes	○yes, Type: ○no
Tinnitus	○yes ○no
Epilepsy	○yes ○no
Glaucoma/ cataract	○yes ○no

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

Do you have any allergies?

○ yes, to _____ ○ no

What medications do you take regularly?

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

Do you have any other diseases?

_____

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

_____

Do you smoke?

○ yes, _____ cigarettes/ day ○ no

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Are you pregnant? How many weeks along are you?

_____

Are you afraid of dental treatments?

_____

Date: _____ Signature: _____

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

○ very good ○ good ○ satisfactory

What do you use for oral hygiene at home?

○ Manual toothbrush	○ Soft ○ Medium ○ Hard	○ Plastic bristles ○ Natural bristles
○ Electric toothbrush		
○ Mouthwash (brand)		
○ Toothpaste (brand)		
○ Dental floss	○ Waxed	○ Unwaxed
○ Interdental brushes		
○ Denture cleaner		
○ Tongue cleaner		
○ Other		

Are you aware of the benefits of professional teeth 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

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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

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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.
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