Dear Patient

A warm welcome to our dental practice Zahnerhaltung. Berlin!

Your health is our top priority. To ensure the widest possible diagnosis and best treatment, we would kindly ask you to fill in the provided form carefully. This is very important to rule out the possible outbreak of general illness during the dental treatment.

We would like to provide you with individual and adequate dental care. Your appointment is reserved for you only.
For any appointment cancelations please inform us at least 24 hours prior.

Personal details

Last name, First name	Date of birth	Place of birth
Address	Postal code	City
Home number	Work number	
Mobile number	Email	

Insurance

Health insurance

- ☐ State insurance
- ☐ Private insurance
- ☐ EU-insurance-card
- ☐ Base rate
- ☐ Government benefits
- ☐ Supplementary insurance

How did you find out about us?

- ☐ Personal recommendation
- ☐ While passing by
- ☐ Refering doctor: _____
- ☐ Internet: _____

please turn

Overall health condition

	Yes	No
High blood pressure	☐	☐
Low blood pressure	☐	☐
Blood-clotting disorder	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Endocarditis	☐	☐
Cardiac pacemaker	☐	☐
Heart disease record card	☐	☐
Other cardiovascular diseases	☐	☐

if so, which: _____

	Yes	No
Thyroid condition	☐	☐
Rheumatoide arthritis	☐	☐
Allergic reactions	☐	☐

if so, which: _____

	Yes	No
Kidney disease	☐	☐
Gastrointenstinal disease	☐	☐
Altered intraocular pressure	☐	☐
Asthma	☐	☐
HIV	☐	☐
Hepatitis	☐	☐
Tuberkulosis	☐	☐

Other health risks:

_____

Medications taken? ☐ ☐

if so, which:

Heart medication: _____

Cortisone: _____

Painkillers: _____

Antidepressant: _____

Blood-thinner: _____

Other: _____

Do you smoke? ☐ ☐

If you are female:

Are you pregnant? ☐ ☐

if so, week: _____

Please do not be surprised! The following question is not intended to be an indiscretion on our part, but serves to ensure compliance with the loading capacity of our treatment units for insurance purposes and thus with the Medical Devices Act (MPG).
Of course, this information is subject to the medical duty of confidentiality!

Do you weigh under 135 kg? ☐ Yes ☐ No

Do you weigh ☐ over 135 kg ☐ over 165 kg ☐ over 200 kg?

You are important to us

	Yes	No
I have received periodontitis therapy once before.	☐	☐
I wish to receive a reminder for my check-ups.	☐	☐

Please check your information and confirm with your signature.

Place, date _____ Signature _____

Place, date _____ Signature _____

If your treatment generates additional costs, of course we will inform you in advance.
We offer the following options for payment:

- Together with our financial partner
  To your advantage: Professional support and correspondence with your health insurance,
  Interest-free partial payment can be arranged
- EC-card or cash payment subsequent to your appointment
  To your advantage: Upon any payments, you can directly submit your invoice to your health insurance

Feel free to ask us for any queries you may have!