Appointment

Welcome to our practice!

Personal Information:

Surname: ________________ First Name: ________________ Born: ___________

Street, No.: _________________________ Post code, Place: __________________________

Telephone No.: _______________________ Mobile: _________________________

Employed by: ________________ Occupation: ______________Telephone No.: _________

Member:

Surname: ________________ First Name: ________________ Born: ___________

Insurance:

Sickness fund resp. health insurance: ______________

Private insurance: **O**

Additional insurance: **O**

Qualified for relief: **O**

Voluntary insurance: **O**

Recommended by: ____

Census form of existing illness

Dear Patient,

Many people are ill. This can also affecting the dental treatment. I therefore ask you to fill in this census form, which will be added to your personal file card. All data are strictly confidential and subject to the medical discretion. Alternations of your personal data to be notified immediately.

Are you under medical care? Yes **O** No **O**

Doctor in charge: ____

Are you suffering:

- acutely or chronically from a circulatory disturbance (heart disease) **O**
- from an infection (hepatitis, TBC, AIDS, etc.) **O**
- from a nervous disease (epilepsy, etc.) **O**
- from a blood disease (proneness to bleed, coagulation defect, etc.) **O**
- from an allergic disease (hypersensitive to medicine, asthma, etc.) **O**
- cardiac pacemaker **O**
- HIV+ **O**
- Marcumar **O**
- from other diseases: ____

To allow a purposeful and appropriate treatment just from the beginning, please answer the following questions.

	Yes	No
Do you have a toothache?	O	O
Are your jaws noisy?	O	O
Do you want to have special advice on avoidance of caries?	O	O
Are you unsatisfied with the aesthetics of your teeth?	O	O
Treatment of parodontitis?	O	O
Treatment of amalgam?	O	O
Ceramic fillings in tooth colour?	O	O
Do you have trouble with your gums?	O	O
Do you have a neck- or headache?	O	O
Treatment of jaw joint?	O	O
Dental prosthesis of high quality?	O	O
Implants?	O	O
Aesthetical dentistry?	O	O
Do you set value local anesthesia?	O	O

Do you presently take any medicine? No **O** Yes **O** _______________

(Female) Pregnant? No **O** Yes **O** _________(Month)

When was you last dental treatment? ____

When was your last X-ray examination? ____

Thank you for your Information!

____

Date and Patient’s Signature

Praxis Dr. Tschackert & Kollegen
Goethestraße 23 60313 Frankfurt am Main Tel.: 069 – 28 30 30 Fax: 069 – 28 30 60
E Mail: praxis@tschackert.com web: www.tschackert.com