Knauf.Kollegen Zahnärzte
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KNAUF.KOLLEGEN
ZAHNÄRZTE

Dear Patient,

We are delighted to welcome you to our dental surgery. Please consult us on your wishes and preferences.
Our team will be happy to advise you on adequate alternatives and to provide individual solutions.

Before we begin, we kindly request you complete this form with your personal details as well as general information on your physical condition. This will help us to ensure the most advantageous and risk-free basis for your dental treatment.

Personal Data: O Mr O Mrs O Ms

Last Name: ______________________ First Name: ____________________________

Adress: ____

Date of Birth: ______________________ Place of Birth: ____________________________

Phone No. (private): ______________________ Phone No. (mobile): __________________________

Insurance: O Private health insurance O German statutory health insurance

Physical condition:

		If yes, which?
Allergies (recorded sensitizers?)?	O yes / O no	_____________________
Attacks (epilepsy, ...)?	O yes / O no	_____________________
Increased intraocular pressure (glaucoma)?	O yes / O no	_____________________
Blood diseases?	O yes / O no	_____________________
Heart diseases (infarction, pacemaker)?	O yes / O no	_____________________
Infectious diseases (hepatitis, HIV, ...)?	O yes / O no	_____________________
Circulatory diseases (blood pressure, ...)?	O yes / O no	_____________________
Liver diseases (hepatitis A/B /C,....)?	O yes / O no	_____________________
Lung diseases (asthma, ...)?	O yes / O no	_____________________
Gastroenteropathy?	O yes / O no	_____________________
Neuronal diseases?	O yes / O no	_____________________
Renal diseases?	O yes / O no	_____________________
Rheumatic diseases / osteoporosis?	O yes / O no	_____________________
Thyroid disease?	O yes / O no	_____________________
Cancer?	O yes / O no	_____________________
Diabetes?	O yes / O no	_____________________
Other diseases?	O yes / O no	_____________________
Past operations?	O yes / O no	_____________________
Do you tend to secondary bleeding?	O yes / O no	_____________________
Are you currently taking any medication?	O yes / O no	_____________________
Are you pregnant? (if yes, which week of pregnancy	O yes / O no	_____________________

Thank you very much!
All information you provide us with is subject to professional discretion and dealt with confidentially.

By signing this document, I confirm the completeness and correctness of the information provided on this form.

Freiburg, __________________ ____
Date Signature