Dr. Klaus Reineck Alexanderstr. 31 64283 Darmstadt

Dear patient,

welcome to our dental office ! It is our aim to help you and make your visit as comfortable as possible under the prevailing circumstances. Please take a few minutes time to read the following questionnaire and answer all questions on both the front and back page correctly and completely.

ALL INFORMATION GIVEN WILL BE TREATED AS STRICTLY CONFIDENTIAL !

Your personal data :

Patient: _____
Surname First name Date of birth

Insured person: _____
Surname First name Date of birth

Adress: _____
Street Town

Telephone: _____
Home Work (Mobile no.?)

Profession: _____ *Employer:* _____

Insurance Company : _____

German Insurance Comp. **O** **Non-German Insurance Comp.** **O**

We do work to an appointment-schedule, which means that we reserve the time necessary for your individual treatment – solely for you! And we try to keep waiting time for you to a minimum – but acute emergencies cannot be forseen, therefore delays and/or postponements can happen.. In such cases we will try to inform you as early as possible and you can then decide whether you wish to wait accordingly, or cancel your appointment and book at another date.

We obviously have to rely on you to come in time for your appointment, or cancel it early (best on the day before, but please no later than 12 hours in advance).

If you miss your appointment without cancellation, the time reserved for you can be charged for - unless it has been used for another patient's treatment.

Please do also complete the page overleaf (Medical Record)

M E D I C A L R E C O R D

Do you –or did you- have any of the following:

O Allergies (which ?) _____

O AbnormaL reactions to medication (which) ? _____

O Cardiaic problems *(„heart murmur")*? _____

O High / low blood pressure? _____

O Respiratory problems ? _____

O Diabetes ? _____

O Thyreoid dysfunction ? _____

O **Hepatitis** / liver dysfunction ? _____

O Kidney *(renal)* dysfunction ? _____

O Prolonged bleeding ? _____

O **Anything else we should know ?** _____

O **Any contagious infections** ? _____ **HIV / AIDS ?** O

O Recurrent gum bleeding ? O Abnormal tooth mobility ?

O Increased muscular tension (jaws) ? O TMJ problems / pain ?

O **Regular medication ?**

O **Are you currently under doctor's instructions / receiving any medical treatment ? Which ?**

_____

Women only: Are you pregnant ? **Yes** O **No** O **Don't know** O

Date of the last x-ray exposition (any) ? _____

If any of the above conditions undergo changes, please notify us before treatment (this also applies to changes of adress or insurance company / insurance status)

Date: _____ Signature: _____