torhaus
IHRE ZAHNÄRZTE

ANAMNESIS

Dear Patient!

Welcome to the torhaus Ihre Zahnärzte dental clinic. Please complete this questionnaire in order to ensure the best possible dental treatment and care. Your personal information is stored electronically in our clinic; It is subject to the statutory data protection regulations (EU General Data Protection Regulation (GDPR), Federal Data Protection Act (BDSG) and medical confidentiality). You can find detailed information about the processing of your personal data in our waiting area.

Your reception team

PATIENT

Gender ☐ m ☐ f ☐ d

Last name, first name | Date of birth | Place of birth

Address | Postal code, city

Home number | Work number | Mobile

E-mail-address | Occupation, employer

INSURANCE

Health insurance

☐ State insurance ☐ Private insurance ☐ Supplementary insurance
☐ European Health Insurance Card ☐ Base rate ☐ Government (state) benefits

If the insured person is not the recipient of the care, please provide the following information about the insurance holder:

Last name, first name | Date of birth

Address | Postal code, city

HOW DID YOU FIND OUT ABOUT US?

☐ Google ☐ Jameda ☐ Other Internet: ____________
☐ Personal recommendation ☐ While passing by ☐ Advertisement: ____________
☐ Other: ____________ ☐ Refering doctor: ____________

torhaus IHRE ZAHNÄRZTE
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10115 Berlin

030 - 95 99 99 400
info@zahnarzt-torhaus.de
www.zahnarzt-torhaus.de

CONTINUE

OVERALL HEALTH CONDITION

	yes	no
High blood pressure	☐	☐
Low blood pressure	☐	☐
Hemophiliac	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Cadiovascular disease	☐	☐

If so, which:

____

____

	yes	no
Thyroid condition	☐	☐
Rheumatoid arthritis	☐	☐
Allergic reactions	☐	☐

If so, which:

____

____

Other diseases:

	yes	no
Infectious disease:		
HIV / AIDS	☐	☐
Hepatitis A, B or C	☐	☐
Tuberculosis	☐	☐

Other:

	yes	no
Medications taken?	☐	☐

If so, which:

- ☐ Heart medication: ______________________
- ☐ Cortisone: ______________________
- ☐ Painkillers / Analgesics: ______________________
- ☐ Antidepressants: ______________________
- ☐ Coagulation inhibitors (e.g. ASS, Marcumar, Heparin): ______________________
- ☐ Other:

	yes	no
Do you smoke?	☐	☐
If you are female:		
Are you pregnant?	☐	☐

If so, how many weeks?: ______________________

ORAL HEALTH

What is the reason for your visit?

- ☐ Check-up
- ☐ Consultation
- ☐ Treatment for pain
- ☐ New denture
- ☐ Dental referral
- ☐ Second opinion
- ☐ Other: ______________________

	yes	no
Are you satisfied with the position, colour and shape of your teeth?	☐	☐
Have you noticed teeth grinding or jaw clenching?	☐	☐
Do you have problems with your gums (e.g. gum bleeding)	☐	☐
Do you suffer from a bad breath or bad taste in mouth?	☐	☐
Do you have an annual professional cleaning of your teeth?	☐	☐
May we remind you of your check-ups and prophylaxis appointments?	☐	☐

Do you have any other questions?

____

For appointments not kept without cancellation, the costs incurred can be invoiced (cancellation fee).
This does not apply in the event of a demonstrably innocent failure to cancel.
We will gladly remind you of your appointments by SMS.

Please confirm the truthfulness of the health information you have provided with your signature below.

____

Place, date Signature

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THANKS