Patient Data Sheet

Neumann + Bähre
Die Prophylaxepraxis

Patient
Family Name _____
First Name _____
Date of Birth _____ Sex ☐ male ☐ female ☐ diverse

Address
Street Address _____
Zip, City, Country _____
Home Phone / Cell Phone _____
Work Phone _____
E-Mail _____
Profession _____

Insurance _____

Company Name _____

Referring Physician – Name, Address, Phone _____

_____

Family Doctor – Name, Address, Phone _____

_____

If insured person is differing from patient mentioned above please fill in

insured person
Family Name _____
First Name _____
Date of Birth _____

Adress
Street Address _____
Zip, City, Country _____

Consent of Treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date _____
Parent/Legal Guardian Signature _____

Please answer the following questions regarding your state of health as exactly as possible

State of Health	Please mark	Further Information
Cardiovascular Diseases		
Hypertension	☐ Yes ☐ No	_____
Hypotension	☐ Yes ☐ No	_____
Valvular Heart Disease / Defect	☐ Yes ☐ No	_____
Endocarditis	☐ Yes ☐ No	_____
Heart Surgery	☐ Yes ☐ No	_____
Pacemaker	☐ Yes ☐ No	_____

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Please answer the following questions regarding your state of health as exactly as possible

State of Health	Please mark	Further Information
Infectious Diseases		
AIDS	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	
other:		
Allergies / Intolerances		
Local Anesthetics	☐ Yes ☐ No	
Analgesics	☐ Yes ☐ No	
Antibiotics	☐ Yes ☐ No	
other:		
Further Diseases		
Coagulation Diseases	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Lung Diseases	☐ Yes ☐ No	
Thyroid Diseases	☐ Yes ☐ No	
Rheumatism	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Nephropathy	☐ Yes ☐ No	
Fainting	☐ Yes ☐ No	
other:		
General Data		
Drug Addiction	☐ Yes ☐ No	
Drinking of alcoholic beverages	☐ Yes ☐ No	If yes: seldom ☐ often ☐ egularly ☐
Smoker	☐ Yes ☐ No	If yes: 0 – 10 ☐ over 10 ☐ cigarettes / day _____
Regular Medication/Drugs	☐ Yes ☐ No	If yes, since when / Name:
X-Rays taken before	☐ Yes ☐ No	If yes, Date / Body Parts:
Gravidity / Pregnancy	☐ Yes ☐ No	If yes, what month:

How did you get informed about our dentist's practice? _____

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Important Information

All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electronically.

I engage myself to inform you immediatelly about all changes occuring during the period of treatment.

I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occuring costs can be invoiced.

I certify with my signature that I have read and understand all above printed information

Date _____

Patient Signature and Parent / Legal Guardian Signature _____