Dr. Frey, Dr. Staufer & Kollegen Zahnärzte

In order to ensure treatment free of unnecessary complications we ask you kindly to fill out this questionnaire and hand it in at reception. Your details will be treated with absolute confidentiality.

patient:_____
surname 1st name date of birth place of birth

member of insurance_____
surname 1st name date of birth

address:_____
street telefone private

_____
code city telefone office

_____
cellphone e-mail tax

occupation_____

employer*:_____

_____
adress telefone

medical insurance:_____ **details**: _____

G.P.:_____

(previous) dentist:_____

Who recommended you to us*?_____

I hereby consent to the storage of my personal data for the purpose of dental treatment by the practice.
I have been advised that I can withdraw this consent at any time in writing or by email to the practice. (Art. 7 Para. 3 DSGVO)
In case of an agreed request for X-rays or shipping, I agree to the encrypted transmission by e-mail to further doctors.

I have received a copy of the Praxis information sheet

Oldenburg,_____ _____
date signature

Please do not forget to answer the questions overleaf!
*No mandatory information

General medical history:

Do you suffer or have you suffered from any of the following illnesses?

1. Heart / circulatory problems-dizziness yes ❑ ❑ no
   If yes, what specifically: high or low blood pressure yes ❑ ❑ no
   Angina pectoris/ heart attack yes ❑ ❑ no
   Stroke yes ❑ ❑ no
   Prone to excessive bleeding yes ❑ ❑ no
   Do you have a pacemaker? yes ❑ ❑ no

Do you have a problem with your health in any of the following areas?

2. Respiratory system ..... yes ❑ ❑ no
3. Digestive system ..... yes ❑ ❑ no
4. Metabolic disorders (e.g diabetes) ..... yes ❑ ❑ no
5. Rheumatic ailments (e.g. rheumatoid arthritis) ..... yes ❑ ❑ no
6. Hormone disfunction (e.g thyroid gland) ..... yes ❑ ❑ no
7. Neurological/mental illnesses ..... yes ❑ ❑ no
8. Infections e.g hepatitis, TB, AIDS ..... yes ❑ ❑ no
9. An allergic reaction, e.g to specific medication, metals, latex ..... yes ❑ ❑ no
   and/or specifically allergic to? _____
   Do you possess an allergy card? yes ❑ ❑ no
10. Are you undergoing medical treatment at present? ..... yes ❑ ❑ no
    If yes, why? _____
11. Are you taking any medications at present? ..... yes ❑ ❑ no
    If yes, what? _____
12. Do you smoke cigarettes, cigars, a pipe etc? ..... yes ❑ ❑ no
    State your average daily consumption _____
13. When was your last X-ray? general _____
    for dental purposes _____

Specific dental history:

1. Have you ever had an accident with head injuries yes ❑ ❑ no
2. Have you ever had orthodontic treatment? yes ❑ ❑ no
3. Do you frequently suffer from headaches? Morning/afternoon/evening yes ❑ ❑ no
4. Do you suffer from earache or pains around your ear? yes ❑ ❑ no
5. Is it painful when you yawn or open your mouth wide? yes ❑ ❑ no
6. Do your jaw joints make noises? Right or left (please circle the side) yes ❑ ❑ no
7. Do your gums bleed? yes ❑ ❑ no
8. Do you have toothache at the moment? yes ❑ ❑ no
9. Do you have any other problems with your teeth at the moment yes ❑ ❑ no
10. Do you prefer to be treated under local anaesthetic? yes ❑ ❑ no
11. Do you wish to avoid particular filling materials, such as amalgam? yes ❑ ❑ no
12. When was your last dentist´s appointment? _____
13. What treatment did you undergo? _____

For female patients: Please inform your dentist if you are pregnant.

Sign. Dentist