Health questionnaire of the Familien-Zahnarztpraxis Isabel Bodenstein

Before starting with the dental treatment we need some information about your health status.
Please fill in the questionnaire.
All answers subject to medical confidentiality of course.

Patient: Surname, Firstname:		**Birthdate** Place of birth	
Insured person: Surname, Firstname		Birthdate Place of birth	
Address:		Phone:	
Postcode/ City/ Country		Mobil:	
E-Mail:			

Employer:		Phone, business:			
Name of health insurance:		Beihilfeberechtigung?	yes	no	
Private health insurance:	If yes, Name:				
Any medical treatment?			yes	no	

Do you have one of the following medical diseases?					
1.	Heartdisease	yes		no	
2.	High blood pressure	yes		no	
3.	Circulatory problems	yes		no	
4.	Asthma	yes		no	
5.	Blood clotting disorder	yes		no	
6.	Liver disease (Hepatitis A, B, C)	yes		no	
7.	Gastrointestinal disease	yes		no	
8.	Diabetes	yes		no	
9.	Epilepsy	yes		no	
10.	Immunodeficience (HIV, AIDS, Tuberkulosis)	yes		no	
11.	Thyroid disease: Hyperthyroidism / Hypothyroidism	yes		no	
12.	Renal disease (Dialysis)	yes		no	
13.	Tumor disease	yes		no	
14.	Osteoporosis	yes		no	
15.	Rheumatism	yes		no	
	Another questions:				
16.	Which medicine do you currently take?				
17.	Are you allergic to certain medicine?	yes		no	
	If yes, which kind?				
18.	Are you pregnant?	yes		no	
	If yes, when is the due date?				
19.	Do you smoke?	yes		no	
20.	Do you have an x- ray pass?	yes		no	
21.	Do you have a dental bonus book?	yes		no	
22.	Do you want a half- yearly recall for a check up per E-Mail?	yes		no	

I know that I have to cancel my appointment 24hrs before. If I don’t do that I have to pay a cancellation fee. I confirm that my information is right.

Signature:		**Date**	