Zahnärzte
Dr. H. Müller & F. Mamede
www.muellermamede.de

Patient registration and medical history

We ask you to answer the following questions carefully so that diseases can be detected early and our treatment measures and medication can be adapted to your state of health.
Of course we treat all your information confidentially!

*Name, first Name:*_____ *date of birth:*_____

*address:*_____

Insured:
*Name, first Name:*_____ *date of birth:*_____

*address:*_____

*Private phone:*_____ *Business phone:*_____ *mobile:*_____

*Email:*_____

*Health insurance:*_____*Do you have additional insurance?* *Yes* ☐ *No* ☐

*When was your last visit to the dentist?*_____
Have your teeth / jaws been x-rayed in the past 2 years? *Yes* ☐ *No* ☐

How did you find out about our practice? _____

General anamnesis: (Please underline as appropriate)
Do you have any allergies? (e.g. against penicillin, aspirin, painkillers, …) *Yes* ☐ *No* ☐
If yes, which?
_____

Do you have an allergy pass?	*Yes* ☐	*No* ☐
Do you suffer or have you suffered from heart disease? Irregular heartbeat?	*Yes* ☐	*No* ☐
cardiac asthma? Angina pectoris? Heart failure (insufficiency)?	*Yes* ☐	*No* ☐
Do you have a pacemaker?	*Yes* ☐	*No* ☐
Do you take anticoagulant medication?	*Yes* ☐	*No* ☐
Do you have high/low blood pressure?	*Yes* ☐	*No* ☐
Do you have a gastrointestinal disease?	*Yes* ☐	*No* ☐
Do you suffer from fainting spells?	*Yes* ☐	*No* ☐
Do you have an increased tendency to bleed? Anemia?	*Yes* ☐	*No* ☐
Do you have a thyroid disease? liver disease? kidney disease?	*Yes* ☐	*No* ☐
Do you have diabetes? (blood sugar)	*Yes* ☐	*No* ☐
If yes, do you need insulin?	*Yes* ☐	*No* ☐
Is there a nervous disorder? Infectious disease (e.g. hepatitis A/B, HIV,...)?	*Yes* ☐	*No* ☐
Asthma? Epilepsy (seizures)?	*Yes* ☐	*No* ☐
Have you ever been prescribed bisphosphonates?	*Yes* ☐	*No* ☐

*Other diseases:*_____

If one of the above questions was answered with "Yes", please give us your name and address your family doctor to:

_____

Do you take any medicine? *Yes* ☐ *No* ☐

*Which?*_____

Do you have pain in the head or neck area? Yes ☐ No ☐

If yes, where? _____

Do you have frequent headaches or migraines? Yes ☐ No ☐

Do you have pain in your teeth or gums? Yes ☐ No ☐

For patients with statutory health insurance (health insurance patients):
Do you want more sophisticated treatment options that not covered by health insurance, be informed? Yes ☐ No ☐

Do you want the best treatment option even if it is not or only partially paid for by health insurance? Yes ☐ No ☐

Would you like to know more about the possibility and the process be informed about individual prophylaxis and oral hygiene? Yes ☐ No ☐

Would you like to take part in prophylaxis in our practice? even if these are not or only partially covered by the health insurance company will be paid? Yes ☐ No ☐

An X-ray examination is often required for a complete diagnosis (one or more x-rays) necessary:

Would you like an X-ray examination if this is necessary? Yes ☐ No ☐

*Are you pregnant? If yes, in which month?*_____ Yes ☐ No ☐

Are you afraid of dental treatments? Yes ☐ No ☐

We offer in our practice to support a relaxed treatment the possibility of nitrous oxide sedation.

You can get more information from our team.

Thank you for your information.

*Munich*_____ _____

(Date) *(Signature)*