Dr. Jochen Herrmann
und Kollegen
Zahnarzt und Oralchirurg

Lindenschmitstraße 44
81371 München
Tel: 089 - 7 25 23 49
Fax: 089 - 7 25 01 07

Welcome to our practice!

Before giving our undivided attention to your wishes we not only need your personal data, but also information on your general state of health. This is important for an adequate and risk-free treatment. All details are subject to medical confidentiality.

Your dentists Dr. Herrmann and colleagues

Patient (Mr./Mrs./child): .....
Last name | First name | Date of birth

In case of dependents' co-insurance: .....
Last name | First name | Date of birth

Address: .....
Street | Number | Phone number (by day)

.....
Postcode | City | Phone number (mobile)

.....
E-mail

Private insurance with: .....

Legal insurance with: .....

Aid insurance: **yes** ☐ **no** ☐

Additional insurance? **yes** ☐ **no** ☐

Occupation: .....

Employer: .....

Appointment approach: notes on organization
If necessary, we will reserve several appointments for you. This helps you avoid long waiting periods and garantuees that we'll be there for you exclusiverly at the date agreed. Please understand that we have to charge missed appointments that weren't cancelled 24 hours before according to GOZ.

All information is subject to medical confidentiality und European General Data Protection Regulation. I agree to the transfer of my data to other attending physicians and master dental technicians.

Please turn over ›

Anamnesis questionnaire

Medical treatment:
Are you currently under medical treatment? **Yes** ☐ **No** ☐

Family doctor/medical specialist:
Name, address and phone number: .....

Medications:
Which medications do you take regularly? .....

Allergies:
To which materials or medications
are you hypersensitive? .....

Cardiac diseases:
Cardiac insufficiency ? **Yes** ☐ **No** ☐
Irregular heartbeat (arrhythmias)? **Yes** ☐ **No** ☐
Cardiac asthma (angina pectoris)? **Yes** ☐ **No** ☐
Pacemaker, cardiac valve replacement? **Yes** ☐ **No** ☐

Vascular diseases:
High blood pressure? **Yes** ☐ **No** ☐
Low blood pressure? **Yes** ☐ **No** ☐
Status post heart attack? **Yes** ☐ **No** ☐
Do you take anticoagulant medications? **Yes** ☐ **No** ☐

Vegetative diseases:
Fainting spells? **Yes** ☐ **No** ☐
Do you take stimulants or tranquilizers? **Yes** ☐ **No** ☐

Metabolic diseases:
Diabetes? **Yes** ☐ **No** ☐
Gastrointestinal diseases? **Yes** ☐ **No** ☐
Thyroid diseases? **Yes** ☐ **No** ☐

Diseases of the nervous system:
Epileptiform convulsions? **Yes** ☐ **No** ☐
Spasms? **Yes** ☐ **No** ☐

Blood disorders:
Bleeding tendency (hemophilia)? **Yes** ☐ **No** ☐
Anemia? **Yes** ☐ **No** ☐

Infectious diseases:
Hepatic inflammation/icterus (hepatitis A, B or C)? Tuberculosis? **Yes** ☐ **No** ☐
Chronic diseases of the respiratory tract, cough etc.? **Yes** ☐ **No** ☐
Have you been tested for HIV? **Yes** ☐ **No** ☐
If yes, with what result? .....

Further details:
Are you addicted to drugs or alcohol? **Yes** ☐ **No** ☐

X-ray:
Were there radiographs taken in the head, jaw and tooth area in the last year? **Yes** ☐ **No** ☐
If yes, where? .....

Pregnancy: **Yes** ☐ **No** ☐
If yes, how many months? .....

Thank you very much for you cooperation! Please inform us immediately about changes in the data noted above.

.....

Date Signature