Zahnärzte im Kantcenter
Dr. Lisa Fache
Wilmersdorfer Str. 108 – 111 / 10627 Berlin
Telefon: 030 / 31991990 – Telefax: 030/31992883

Medical history

Surname: _____

Forename: _____

Date of birth: _____

Adress: _____

Postal code/City _____

Tel. home number: _____

Tel. mobile: _____

E Mail: _____

Business: _____

Taskmaster, City _____

Tel. Business: _____

Health insurance: _____

If you are co-insured, who is the insured person?

Surname: _____

Forename: _____

Date of birth: _____

Who should receive the account?

Name: _____

Adress: _____

_____

Law insurance? ( ) yes / ( ) no

Compulsorily insured? ( ) yes / ( ) no

Additional insured? ( ) yes / ( ) no

Aid insurance? ( ) yes / ( ) no

Privately insured? ( ) yes / ( ) no

Privately insured, with standard rate? ( ) yes / ( ) no

Who has recommended us? _____

How did you find us? _____

I hereby absolve the above-named dentist of the medical confidentiality concerning the carried out dental treatments with me or my child compared to the dentists practice community “dentists in the center square” and to the BFS Finance. I agree with the distribution of the relevant treatment data.

Yes	No	
( )	( )	May we inform you about what is possible with newer and better dental supplies, even if these benefits are not taken over by health insurance or only partially?
( )	( )	Would you be informed by us that the best possible dental care to?
( )	( )	Would you be particularly informative on our intensive prevention program?

Organization Information:
We will, if necessary, reserve several dates for you. This saves you from long waits at the agreed date and we are there for you. Quality work is only possible without time pressure. Please understand that we missed deadlines that were not canceled timely invoice. Should be no fault of the non-appearance, it is considered appropriate.

_____ _____ _____

Date Sign Sign legal representative / guardian

Please contact

Dear patient,

Certain diseases or pregnancy must be considered essential to avoid unnecessary complications in the treatment. In your own interest we ask you to answer the following questions fully. Your details are naturally subject to medical confidentiality. Please advise us of any changes in your health before starting any treatment.

Yes No (Please tick)

( ) ( ) Do you have cardiovascular disease? If so, what? _____

( ) ( ) Are you sensitive or have allergies to certain substances, drugs, metal, etc.?
What?_____

( ) ( ) Do you have joint implants? Synth., Heart valves or the pacemaker ?

( ) ( ) Are you HIV positive?

( ) ( ) Do you have hepatitis A/B/C?

( ) ( ) You taking any medications for blood clotting ? What? _____

( ) ( ) Take one more medication? What? _____

( ) ( ) Do you have diabetes mellitus?

( ) ( ) Do you have a thyroid disease?

( ) ( ) Do you have a stomach / intestine / kidney disease?

( ) ( ) Do you suffer from migraines?

( ) ( ) Do you have glaucoma?

( ) ( ) Do you have a prostate disease?

( ) ( ) Do you have asthma?

( ) ( ) Are you pregnant? If yes, what week?_____

( ) ( ) Other diseases? _____

Why you go into treatment?

( ) ( ) Toothache?

( ) ( ) Withdraws your gums?

( ) ( ) Do your gums bleed?

( ) ( ) Are your teeth loose?

( ) ( ) Do you have discomfort in the jaw joint?

( ) ( ) Do you wish a reminder (recall) for professional dental cleaning and/or a preventive dental checkup appointment?
per e-mail ( )
per postcard ( )

Please answer the questions in their own interest. Confidentiality is our part of course. I have made confirm the above information to the best knowledge and belief.

_____ _____ _____
Date Sign Sign legal representative / guardian