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

Medical history

Surname: _____

First name: _____

Date of birth: _____

Address: _____

Postal code/City _____

additional address c/o: _____

Tel. home number: _____

Tel. mobile: _____

E Mail: _____

profession: _____

Employer, City _____

Tel. Business: _____

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

Surname: _____

Forename: _____

Date of birth: _____

Who should receive the bill? (for minor patients)

Name: _____

Address: _____

_____

Health insurance: _____

Statutory / legally insured? ( ) yes / ( ) no

supplementary insured? ( ) yes / ( ) no

Private insured? ( ) yes / ( ) no

Private insured, with basic tariff? ( ) yes / ( ) no

Are you beneficiary of public service? ( ) yes / ( ) no

How did you find us? Who has recommended us?

_____

I hereby release the above-named dentist from the medical confidentiality obligation concerning the carried out dental treatments with me or my child towards the dentists of the joint practice "Zahnärzte im Kantcenter" and to the BFS finance. I agree with the transmission of the relevant treatment data.

Organizational information:
We will, if necessary, reserve several appointments for you. This avoids long waiting times at the agreed date and we can be there for you. High-quality work is only possible without time pressure**. Please understand that we will charge you for missed appointments, which were not canceled at least 24 hours in advance.** If the non-appearance is out of your responsibility, e.g. due to illness, the charges will be dropped.

_____ _____ _____

Date Sign Sign legal representati ve / guardian

please turn the page →

Dear patient,

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

Yes No (Please tick)

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

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

( ) ( ) Do you have joint implants? Synth., Heart valves or pacemaker? Since when: _____

( ) ( ) Are you HIV positive?

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

( ) ( ) do you take medication that may influence blood coagulation? Which?: _____

( ) ( ) do you take any other medication? Which? _____

( ) ( ) Do you have diabetes mellitus? Which type: _____ / HbA1C Value: _____

( ) ( ) Do you have a thyroid disease?

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

( ) ( ) Do you suffer from migraine?

( ) ( ) Do you have glaucoma?

( ) ( ) Do you have a prostate disease?

( ) ( ) Do you have asthma?

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

( ) ( ) Other diseases? _____

What is the reason of your visit?

( ) ( ) Toothache?

( ) ( ) Did your gums withdraw?

( ) ( ) Do your gums bleed?

( ) ( ) Are your teeth loose?

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

( ) ( ) Are you unsatisfied with the position of your teeth?

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

Please answer the questions in your own interest. Confidentiality of course remains guaranteed. I hereby confirm giving the above information to the best of my knowledge, correct and complete

_____ _____ _____
Date Signature Signature legal representative / guardian