



Dear Patient

A warm welcome to our dental practice Zahnerhaltung.Berlin!

Your health is our top priority. To ensure the widest possible diagnosis and best treatment, we would kindly ask you to fill in the provided form carefully. This is very important to rule out the possible outbreak of general illness during the dental treatment.

We would like to provide you with individual and adequate dental care. Your appointment is reserved for you only. For any appointment cancelations please inform us at least 24 hours prior.

Personal details

Last name, First name

Date of birth

Place of birth

Address

Postal code

City

Home number

Work number

Mobile number

Email

Insurance

Health insurance

State insurance

Private insurance

EU-insurance-card

Base rate

Government benefits

Supplementary insurance

How did you find out about us?

Personal recommendation

While passing by

Referring doctor: _____

Internet: _____

please turn 

Overall health condition

	Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood-clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberkulosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other health risks:		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Medications taken?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	if so, which:		
Heart disease record card	<input type="checkbox"/>	<input type="checkbox"/>	Heart medication: _____		
Other cardiovascular diseases	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone: _____		
if so, which: _____			Painkillers: _____		
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant: _____		
Rheumatoide arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood-thinner: _____		
Allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
if so, which: _____			Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	If you are female:		
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Altered intraocular pressure	<input type="checkbox"/>	<input type="checkbox"/>	if so, week: _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			

You are important to us

	Yes	No
I am aware of professional dental cleaning care.	<input type="checkbox"/>	<input type="checkbox"/>
I have received periodontitis therapy once before.	<input type="checkbox"/>	<input type="checkbox"/>
I wish to receive a reminder for my check-ups.	<input type="checkbox"/>	<input type="checkbox"/>

Please check your information and confirm with your signature.

_____	Place, date	_____	Signature
_____	Place, date	_____	Signature
_____	Place, date	_____	Signature

If your treatment generates additional costs, of course we will inform you in advance.
 We offer the following options for payment:

- Together with our financial partner BFS health finance
 To your advantage: Professional support and correspondence with your health insurance,
 Interest-free partial payment can be arranged
- EC-card or cash payment subsequent to your appointment
 To your advantage: Upon any payments, you can directly submit your invoice to your health insurance

Feel free to ask us for any queries you may have!