Patient Questionnaire

DR. VON RAKOWSKI
ZAHNARZT PRAXIS MÜNCHEN

Welcome to the Dental Office Praxis Dr. von Rakowski!

Please answer the following questions about your state of health as accurately as possible. If you are unsure of anything, please do not hesitate to ask.
General diseases can have effects on the dental-medical treatment. So, we ask you to fill out this questionnaire. They serve exclusively to adapt our treatment to your state of health. Partly they are regulated by law. This information is subject to medical privacy and data protection laws and will be handled with strict confidentiality.

Patient details

Last name, first name: _____ Date of Birth: _____

Postcode, City: _____ Street and number: _____

Phone private (landline): _____ Phone work: _____

Mobile number: _____ Email: _____

Profession: _____ Employer: _____

Insurance details

Health Insurance: _____

Statutory health Insurance: ❍ yes ❍ no Private insurance: ❍ yes ❍ no

Supplemental insurance: ❍ yes ❍ no Base rate ❍ yes ❍ no

In case the owner of your insurance is someone else than you, please tell us the following details about this person:

Last name, first name: _____ Date of Birth: _____

Postcode, City: _____ Street and number: _____

Family doctor

Name: _____ Address: _____

Phone: _____

How did you hear about us?

❍ Friend / Family ❍ Walk-by ❍ Physician referral ❍ Internet/ website ❍ Other

We offer a text/ SMS service to inform about your upcoming appointment.
Do you want us to arrange this service for you? ❍ yes ❍ no

We offer a free recall service to inform our patients about the regular half-yearly dental check-up and professional teeth cleaning. It is without obligation for both sides.

Do you want us to arrange this service for you? ❍ yes ❍ no
If yes, do you prefer the correspondence per? ❍ Mail ❍ SMS

Reason for your visit?

❍ Check-up ❍ Dentures ❍ Advice ❍ Second opinion

❍ Pain treatment ❍ Other: _____

Are you concerned about or experiencing any of the following dental problems?

Do you have a toothache? ❍ yes ❍ no
Are you experiencing pain or discomfort with pressure or chewing? ❍ yes ❍ no
Are you experiencing constant pain? ❍ yes ❍ no
Are you experiencing pain or discomfort without pressure? ❍ yes ❍ no
Sensitivity to sweet or sour? ❍ yes ❍ no
Sensitivity to hot or cold? ❍ yes ❍ no

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Are your gums sensitive or inflamed? ❍ yes ❍ no
Do you get regular professional teeth cleaning? ❍ yes ❍ no
Do you smoke? ❍ yes ❍ no
Clicking/ pain in the jaw joints? ❍ yes ❍ no

Are you experiencing bad breath? ❍ yes ❍ no
Do you have bleeding gums? ❍ yes ❍ no
Are you happy with your teeth (colour/ shape)? ❍ yes ❍ no
Do you grind/ clench your teeth? ❍ yes ❍ no

Medical History

Have you ever had or are suffering from any of the following?

Liver disease ❍ yes ❍ no
Kidney disease ❍ yes ❍ no
Thyroid disease ❍ yes ❍ no
Stomach or digestive condition ❍ yes ❍ no
Rheumatism (joint pain) ❍ yes ❍ no
Lung Disease (eg. Bronchitis) ❍ yes ❍ no
Spine/ Neck / Back problems ❍ yes ❍ no
Heart Disorder/ Complaint ❍ yes ❍ no
If yes, what kind?

_____

_____

Have you ever had or are suffering from any of the following?

High/ low blood pressure ❍ yes ❍ no
Diabetes ❍ yes ❍ no
Ringing in the ears/ Tinnitus ❍ yes ❍ no
Epilepsy/ epileptic seizure ❍ yes ❍ no
Glaucoma ❍ yes ❍ no
Tuberculosis ❍ yes ❍ no
HIV (Aids) ❍ yes ❍ no
Hepatitis ❍ yes ❍ no
If yes, what type? ❍ A ❍ B ❍ C
Allergies ❍ yes ❍ no
If yes, against what?

_____

Any other Condition(s) not mentioned (Please list):

_____

_____

Are you taking any medicine currently or regularly?

❍ cardiac drugs ❍ cortisone
❍ painkillers ❍ antidepressants
❍ blood thinners (Marcumar, ASS, Xarelto, Plavix, Eliquis)
❍ Bisphosphonates
❍ additional medication

_____

_____

Do you have intolerances to medication or local anaesthesia/ injections? ❍ yes ❍ no
If yes, against what?

_____

_____

For Women:

Are you pregnant? ❍ yes ❍ no

If yes, how many weeks? _____

Be careful after local anaesthetic. Numbness will resolve over the next several hours, therefore avoid hot food and drinks and until the anaesthesia wears off. Take care to avoid biting your lip or tongue at this time. Children should be observed until the anaesthesia has worn off.

By my signature, I declare, that I have filled in this form to the best of my knowledge and I agree to immediately report any and all changes arising during the entire treatment period.
Patients under the age of 18 require a declaration of consent of the legal guardian. Acute pain treatments are the exception.

_____
Signature of the patient/ legal guardian

_____
Place, date

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Additional Information

I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

_____ _____

Signature of the patient/ legal guardian

Place, date

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Text / SMS appointment reminder service

Dear patient,

we offer a text/ SMS service to inform about your upcoming appointment. Please fill in the information below if you want us to arrange this service for you.

Last name, first name: _____ Date of Birth: _____

Mobile number: _____

_____
Signature of the patient