AVADENT CLINIC
Zahnmedizin einer neuen Generation.

MEDICAL HISTORY AND REGISTRATION

family name: ..... first name: .....

date of birth: ..... postcode / zip: .....

street / no.: ..... city: .....

phone privat: ..... business: .....

mobile: ..... e-mail: .....

Profession: ..... employer: .....

Health Insurance: .....

■ Eligible for government allowance ■ Private health care ■ Supplementary privat insurance ■ Privately insured to base rate

INVOICE RECIPIENT (FOR NON-SELF-INSURED PATIENTS):

family name: ..... first name: .....

date of birth ..... postcode / zip: .....

street / No.: ..... city: .....

General practitioner: ..... city: .....

Refering Specialist/ (dentist): ..... city: .....

HOW DID YOU FIND OUT ABOUT US?

Referral ■

Recommandation friends / acquaintance ■

Phone Book / yellow pages ■

Internet ■

Press advertisement ■

Lecture ■

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In order to suit your individual needs, please be so kind and complete the following questionnaire on the next page.
We assure that your personal data are treated strictly confidential:

AVADENT CLINIC DR. HENRICH & COLL.

AVADENT.DE

Am Mühlberg 6–8 61348 Bad Homburg T 06172-307777 F 06172-307778 badhomburg@avadent.de
Gartenstraße 2 61476 Kronberg T 06173-78778 F 06173-940974 kronberg@avadent.de

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HEALTHQUESTIONS

Do you suffer from any following diseases? Please mark.

Cardiovascular disease: Cardiac heart disease (CHD) / angina – myocardial infarction – coronary blood vessel disease - dysrhythmia – pacemaker – valvular transplant – congenital cardiac anomalies – endocarditis – high or low blood pressure - stent	■
Bleeding problems or disorders (haemophilia)? Are you in an anticoagulant treatment?	■
Diabetes	■
Do you have an artificial joint or prothesis?	■
Do you take bisphosphonate medicine (e.g. Fosamax)?	■
Thyroid disease	■
Respiratory system diseases (e.g. asthma)?	■
Gastrointestinal tract disease	■
Infections: hepatitis – HIV – tuberculosis – other:	■
Liver disease	■
Kidney disease	■
Do you have any allergies or intolerances (e.g. penicillin, antibiotics, analgesics, latex, synthetics or metal)? Or against:	■
Tumordisease (present and past) cancer – radiation – chemotherapy	■
Central nervous system diseases (e.g. epilepsy, headache, migraine, sleep disorder, faint, nervousness, stroke)?	■
Do you smoke?	■
Are you taking any medication? If yes, please list:	
Are you on a medical treatment of other diseases?	■

Do you like your tooth color?	yes ■	no ■
Do you often have headaches and neck pains?	yes ■	no ■
Are you pregnant?	yes ■	no ■

Please notify: To the best of my knowledge, all of the preceeding answers are correct. In case of any changes I will inform you at the next appointment.

Informed consent/Patient Agreement: I agree that all members of AVADENT CLINIC Dr. Henrich & Coll. are allowed to view personal data that I delivered from outside (e.g. results or X-rays) and that only anonymized data and records that were collected here can be used for scientific studies.

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Date Signature of patient or legal representive

Formular versenden

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