ZAHNARZTPRAXIS
Dr.med. dent. Marcus Moghadam
und Kollegen

Your Medical History

For an ideal dental treatment we would like to ask you for some information about yourself. Therefore, we kindly ask you to fill out the following questionnaire as accurately as possible. We will be happy to assist you with any further questions. All details are subject to medical privacy and German data protection laws and will be handled with strict confidentiality.

General patient data

Surname: ______________________
First name: ______________________
Date of birth: ______________________

Address

Street: ______________________
Postal code: ______________________
City: ______________________
Phone: ______________________
Mobile: ______________________

Optional data

Primary physician: ______________________
Address: ______________________
Phone: ______________________

Last dentist: ______________________
Address: ______________________
Phone: ______________________
Last visit: ______________________

Occupation/Employer: ______________________
Address: ______________________
Phone: ______________________

Insurance data

German statutory health insurance, subject to compulsory insurance ☐
Coverage from a private health insurance ☐ Coverage from a private health insurance (basic tariff) ☐
Voluntary member of the German statutory health insurance ☐
Name of health insurance: ______________________
Family insured ☐
Surname, first name, date of birth of insured person: ______________________

Your Medical History

Are you in any current medical treatment? .... Yes ☐ No ☐
Have you ever undergone major surgery in hospital? .... Yes ☐ No ☐
Did you ever suffer from a severe disease? .... Yes ☐ No ☐
Is there any current medication? .... Yes ☐ No ☐
If so, which one? ______________________

Are you suffering from one of the following diseases?

Rheumatism ☐ Icterus (hepatitis) ☐ High blood pressure ☐
Tuberculosis ☐ Sexually transmitted disease ☐ Stroke ☐
Cardiac disease ☐ Asthma, hay fever ☐ Kidney insufficiency ☐
HIV, AIDS ☐ Diabetes, sugar ☐ Other: ______________________

Is there any disconcerting reaction (allergy) to one of the following medication/substances?

Aspirin/ASS ☐ Iodine ☐ Sulfonamide ☐
Nickel ☐ Gold ☐ Penicillin ☐

Do you have an acute or chronic disorder of the cardiovascular system (i.e., the heart and blood vessels)? Yes ☐ No ☐
Only females: Is there a suspicion of a current pregnancy ? Yes ☐ No ☐
Only females: Are you taking oral contraceptives (the pill) ? Yes ☐ No ☐

Place, date: ______________________ Signature: ______________________