Zahnarztpraxis Dr. Mathias Reisch
Prenzlauer Allee 180
10405 Berlin

Medical history

To complete your medical record, we need the following information, which are subject tot he duty of medical confidentiality and to data protection and which are treated by us as strictly confidental. Please keep our practice informed of any changes in your state of health, your address and your insurance status in the future.

Patient: _____
(Mr / Mrs / Child) Surname First Name Date of birth

Address: _____
Street / No. Post code / city

Contact details: _____
telephone / mobile E-Mail

Would you like an appointment reminder via SMS?: ☐ yes ☐ no

insurance: ☐ public insurance ☐ private insurance

parents for their children: _____
(bei Kindern) Surname First name Date of birth

_____
Street / No. Post code / city telephone / mobile

Do/Did you have one oft he following diseases?

☐ Asthma
☐ Diabetes
☐ Rheumatism
☐ Osteoporosis
☐ Tuberculosis
☐ HIV Infection
☐ Blood disorders
☐ Blood coagulation disorders
☐ MRSA hospital germ
☐ Liver diseases
☐ Hepatitis A/B/C
☐ Seizure disorders (epilepsy)
☐ Thyroid diseases
☐ Renal impairment
☐ Tumor/Carninoma/Cancer
☐ Do/Did you take bisphosphonates

Any existing allergies? ☐ yes ☐ no If yes, which one(s)? _____
Heart attack ☐ yes ☐ no Stroke ☐ yes ☐ no
Paralyzes ☐ yes ☐ no
Do you take any blood thinners? ☐ yes ☐ no If yes, which one(s)? _____
Blood pressure: ☐ low ☐ normal ☐ high
Do you have a cardiac pacemaker? ☐ yes ☐ no
Do you have stens? ☐ yes ☐ no
Do you regularly take medicine? ☐ yes ☐ no

If yes, which one(s)? _____

_____

Do you smoke? ☐ yes ☐ no
Do you have any addictions? ☐ yes ☐ no If yes, which one(s)? _____
Are you pregnant? ☐ yes ☐ no ☐ uncertain
Do/did you have any injuries resulting from an accident in the area of mouth, jaw oder face? ☐ yes ☐ no

Other informations/Other diseases: _____
Does a care dependancy exist? ☐ yes ☐ no If yes, to which degree? _____
Do you have a bonus book? ☐ yes ☐ no

With my signature I confirm the completeness and correctness of the above information.

_____
Date Signature of patient or parent