Dr Schumacher FELDBERG 5

Welcome to Dr. Schumacher's dental practice.

Before we can discuss your personal treatment plan with you, we need some details from you, including information about your general health. This is important to ensure your dental treatment is both safe and effective.
Any details given will be kept absolutely private, as is the case with medical records any Doctor holds for you.

Your dentist is Dr. med. dent. Petra Schumacher

Patient
Mr/ Mrs/ Child

First Name _____ Last Name _____ Date of Birth _____

Member _____

Address

Street _____ No. _____ Telephone Private/Daytime _____

Postcode _____ Town _____ Email Address _____

'Krankenkasse'
or Health Insurance _____

Membership No. _____

Profession _____

Recommended by _____

How would you rate your smile on a scale from 1 to 10?

Encircle please 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐ Straight teeth ☐ Whiter teeth ☐ Replace broken / missing teeth

In particular, would you like to be informed about our comprehensive prevention programme?

☐ Yes ☐ No

Would you like to be reminded by us when your next appointment is due?

☐ Yes ☐ No

For 'Krankenkasse' Patients

We will need your Health Insurance (Krankenkasse) ID card whenever you visit the practice. If it is not presented within 14 days of your first treatment, you will be classified as a private patient, and billed according to the official price list. Would you like us to keep you up to date on new advances and possibilities in dental health and treatment? Please note that some treatments may be covered only partly or not at all by your health insurance or Krankenkasse.

☐ Yes ☐ No

Request to all our patients

We do our utmost to keep waiting times short. We would therefore ask you to give us at least 24 hours notice if you are unable to keep an dentist appointment. We are entitled to bill patients for missed appointments according to the official regulated price list, even if patients are normally insured as a member of an insurance scheme or Krankenkasse. Please bear in mind that our schedule also has to accommodate people who are in pain – this sometimes causes delays.

Date _____ Signature _____

Admission Form

Medical Treatment

Are you undergoing medical treatment at the moment? ☐ Yes ☐ No
If yes, for which illness? _____

Doctor / Specialist

Name, Address & Telephone Number: _____

_____

Medication

Which materials or medicaments
Are you believed to be allergic? _____
Do you hold an allergy Pass? ☐ Yes ☐ No

Heart Conditions

Weak heart? ☐ Yes ☐ No
Irregular heartbeat? ☐ Yes ☐ No
Angina (Angina pectoris)? ☐ Yes ☐ No
Pace-maker or similar? ☐ Yes ☐ No

Other: _____

Circulation

High blood pressure? ☐ Yes ☐ No
Low blood pressure? ☐ Yes ☐ No
Condition following heart attack? ☐ Yes ☐ No
Do you take medicine against blood-clotting? ☐ Yes ☐ No

Other: _____

Consciousness

Do you suffer fainting attacks? ☐ Yes ☐ No
Are you taking stimulants or calming medication? ☐ Yes ☐ No
Other: _____

Digestive Problems

Diabetes? ☐ Yes ☐ No
Stomach or intestinal problems? ☐ Yes ☐ No
Thyroid gland problems? ☐ Yes ☐ No

Other: _____

Nervous Disorders

Epilepsy? ☐ Yes ☐ No
Cramps? ☐ Yes ☐ No

Other: _____

Blood Disorders

Haemophilia? ☐ Yes ☐ No
Anaemia? ☐ Yes ☐ No

Other: _____

Infections

Liver Cirrhosis/Hepatitis A/B/C? ☐ Yes ☐ No
Tuberculosis? ☐ Yes ☐ No
Chronic chest diseases, coughing etc.? ☐ Yes ☐ No
Have you had an AIDS test? ☐ Yes ☐ No

If yes, what was the result? _____

Other: _____

Further Details

Are you dependent on alcohol or any other drugs? ☐ Yes ☐ No

X-Rays

Have you had a head, mouth or dental X-ray within the past year? ☐ Yes ☐ No

If yes, where? _____
Our modern X-ray devices are designed to reduce radiation to the absolute minimum necessary.

Pregnancy

If yes, in which month are you? _____

Many thanks for your assistance. Please inform us immediately if any of the above details should change.

Date _____ Signature _____

Dr. med. dent. Petra Schumacher
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und dentale Präventivmedizin
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