medical history

Dr. Koenigsfeld

patient ______ last name ______ name ______ DOB

member / insured party ______ last name ______ name ______ DOB

address ______ street ______ No. ______ Telephone number

______ zip cpde ______ city ______ Mobile number

email address ______

profession ______ employer ______

health insurance ______ additional insurance ______

Do you suffer from any of the following?	yes	no	additional information
1. Coronary diseases (i.e. Heart, blood pressure)	☐	☐	
2. Infectious diseases (i.e. Hepatitis, AIDS, HIV, Tuberculosis)	☐	☐	
3. Internal ailments (i.e. Diabetes, blood clotting disorder)	☐	☐	
4. Allergies (including medications)	☐	☐	
5. Are you currently taking any medications?	☐	☐	
6. Other diseases:	☐	☐	
7. Are you currently pregnant?	☐	☐	
8. Are you anxious about dental treatments?	☐	☐	
9. Do you smoke? If so, how many cigarettes per day?	☐	☐	
10. Do you want us to send you reminders?	☐	☐	
11. Have you had any x-rays taken of your jaw within the last six months? If so, who took them?	☐	☐	
12. Did your dentist refer you to our surgery?	☐	☐	
13. Are you content with the colour of your teeth?	☐	☐	
14. What is the reason for your visit to our surgery?			
15. How did you hear about us?			

Date ______ Signature (To be signed by parent/guardian if the participant is under 18 years of age.) ______

In accordance with BGB § 615, we will charge you a cancellation fee of €100.00 for unexcused missed appointments or short-notice cancellations (<12 hours before the appointment).