Welcome to

Zahnarztpraxis
Bodenseestraße
Dr. Michael Konrad
Dr. Jana Konrad

In order to offer you our best service and to treat you individually, we kindly ask you to fill out our anamnese bow. Please take special care with the questions concerning your health status. All data are subject to medical confidentiality as well as to the provisions of the data protection and are treated strictly confidential.

Thank you for your compliance.
Your team of Bodenseestraße Dr. Michael und Dr. Jana Konrad

---

surname, first name _____ title _____ date of birth _____

street, number _____ zip code _____ residence _____

privat phone _____ mobile _____ phone at work _____

email _____ insurance company _____

Place of birth _____ profession _____

surname, first name of principal member _____ date of birth of principal member _____

if family insured

street, number of principal member _____ zip code _____ residence _____

a possible invoice should be send
☐ to my address.
☐ to the address of the principal member.

☐ I am privately insured.

I have a supplementary insurance for:

☐ prophylaxis / professional tooth cleaning

☐ preserving treatments (e.g. fillings, root canal treatments)

☐ restorative treatments (e.g. crowns, bridges, dentures)

☐ dental implants

Zahnarztpraxis
Bodenseestraße
Dr. Michael Konrad
Dr. Jana Konrad

Are you currently undergoing medical treatment?

☐ yes ☐ no

If yes, why?

_____

Doctor, who is treating you

name: _____

address: _____

phone: _____

Are you pregnant?

☐ yes ☐ no which month?_____

Do you regularly take medication, and if so what kind?

_____

_____

_____

Do you have allergies or allergic reactions to?

local anesthesia	☐ yes	☐ no
painkillers	☐ yes	☐ no
antibiotics	☐ yes	☐ no
asthma bronchiale	☐ yes	☐ no
hay fever / house dust	☐ yes	☐ no
latex / band-aid / iodine	☐ yes	☐ no
food allergies	☐ yes	☐ no

anything else?

_____

_____

_____

Do you have an allergy pass? ☐ yes ☐ no

cardiovascular diseases

high blood pressure	☐ yes	☐ no
low blood pressure	☐ yes	☐ no
cardiac insufficiencies	☐ yes	☐ no
angina pectoris	☐ yes	☐ no
state after heart attack	☐ yes	☐ no
state after stroke	☐ yes	☐ no
cardiac arrhythmia	☐ yes	☐ no
cardiac pacemaker	☐ yes	☐ no
diseases of the cardiac muscle	☐ yes	☐ no
heart valve defect / replacement	☐ yes	☐ no

Do you have an cardiac pass? ☐ yes ☐ no

anything else?_____

blood disorders

coagulations disorders	☐ yes	☐ no
anemia	☐ yes	☐ no

anything else?_____

Do you use blood thinners or coagulation inhibitors ☐ yes ☐ no

if so which ones?_____

_____

Neurovegetative illnesses?

faintings / blackouts ☐ yes ☐ no

Do you use stimulants, tranquillizers or psychotropic drugs ☐ yes ☐ no

anything else?_____

metabolic disorders

diabetes	☐ yes	☐ no
gastro-intestinal diseases	☐ yes	☐ no
diseases of the thyroid gland	☐ yes	☐ no
diseases / anomalies of the kidney	☐ yes	☐ no

anything else?_____

infectious diseases

hepatitis a/b/c	☐ yes	☐ no

which?_____

HIV / AIDS	☐ yes	☐ no
tuberculosis?	☐ yes	☐ no

anything else?_____

recent x-rays of the head / teeth yes ☐ no

where, by whom?_____

_____

Other diseases

Creutzfeldt-Jakob disease	☐ yes	☐ no
glaucoma	☐ yes	☐ no
epilepsy	☐ yes	☐ no
do you snore	☐ yes	☐ no
osteoporosis	☐ yes	☐ no
depressions	☐ yes	☐ no
cancer / tumor	☐ yes	☐ no
drug addicted	☐ yes	☐ no
alcohol consumption	☐ yes	☐ no
cigarettes, per day? _____	☐ yes	☐ no

Zahnarztpraxis
Bodenseestraße
Dr. Michael Konrad
Dr. Jana Konrad

other important medical information: _____

_____

_____

When was your last visit at a dentist‘s? _____

How did you find out about us?

_____

Important information

All data are subject to medical confidentiality as well as to the provisions of the data protection and are treated strictly confidential.

I agree with the collection and processing of my personal data for the purpose of dental treatment and a resulting invoicing, if necessary via an external settlement company. In addition I undertake to inform the dental office and the dentist about changes to my health condition immediately. I understand, that individual appointments are made to meet my personal treatment and thus time is reserved for this purpose. In case I need to cancel the appointment, I am to inform the office 24 hours in advance. Clients who do not keep their appointments will pay for the cost of the appointment. With my signature I confirm that all information above is correct and that I have read and understood the above agreement and that I consent to proceed with the treatment.

Ailingen, _____ _____

date signature