Kottident

WE ARE DELIGHTED THAT YOU ENTRUST US WITH YOUR DENTAL HEALTH!

Systemic diseases can often affect the dental treatment. In order to select the best possible medications and methods for your treatment, we therefore ask you to carefully read and complete this questionnaire as accurately as possible before your first treatment. Please tick each relevant checkbox (☒ = yes, applies ☐ = no, does not apply) and answer the questions on the reverse side. All information is subject to medical confidentiality and will not be disclosed to others. Should you be a little uncertain about a specific question don't hesitate to ask us.

WHAT IS THE REASON FOR YOUR VISIT?

- ☐ Check-up
- ☐ Toothache
- ☐ Migraine / head and neck pain
- ☐ Halitosis (bad breath)
- ☐ TMJ (jaw joint) problems
- ☐ Bleeding gums
- ☐ Gnashing of teeth
- ☐ Dental Aesthetics / Cosmetics
- ☐ Dentures / Prosthetics
- ☐ Ceramic fillings
- ☐ Amalgan restoration
- ☐ Prophylaxis
- ☐ Other:

.....

CONTACT INFORMATION OF THE PATIENT HOW CAN WE REACH YOU?

.....
Last name, Frist name

.....
Street, House number

.....
City, Postcode

.....
Phone

.....
Email

.....
Date of birth

CONTACT INFORMATION OF THE PAYER, IF DIFFERENT:

.....
Last name, Frist name

.....
Street, House number

.....
City, Postcode

.....
Phone

.....
Email

HOW ARE YOU INSURED?

- ☐ Statutory health insurance
- ☐ Private insurance - not the basic tariff
- ☐ Private insurance - basic tariff
- ☐ Eligible for aid
- ☐ Additionally insured:

.....

CONTACT OF YOUR FAMILY DOCTOR:

.....
Name of physician or practice

.....
Street, House number

.....
City, Postcode

.....
Phone

INFORMED CONSENT FOR THE TREATMENT OF MINORS

The informed consent of the legal guardian is necessary if the patient has not yet reached the age of 18, except in case of an acute pain treatment.

.....
Signature, Date

Kottident

Please tick each relevant checkbox (☒ = yes, applies ☐ = no, does not apply)

GENERAL QUESTIONS:

Do you smoke? ☐
If so, how many cigarettes per day? ☐☐ *pc*

Do you regularly drink alcohol? ☐

Do you use drugs or stimulants? ☐

Do you suffer from a fainting tendency? ☐

Are you pregnant? ☐
If so, in what week? ☐☐ *w*

Previous X-ray examinations ☐
If so, when, and what body parts?

.....

Are you currently taking any medications? ☐
If so, which?

.....

Have there ever been any complications in previous dental work or treatments? If so, which ones?

.....

Do you suffer from excessive bleeding after tooth extractions? (possibly due to the drug warfarin) ☐

DO YOU SUFFER FROM ALLERGIES?

Local anesthetics ☐

Intolerances to drugs ☐
(for example iodine, penicillin)

Pain medications ☐

Antibiotics ☐

Metals ☐

Others: ☐

.....

HAVE YOU EVER SUFFERED FROM ONE OF THE FOLLOWING CARDIOVASCULAR DISEASES?

High blood pressure *(hypertension)* ☐

Low blood pressure *(hypotension)* ☐

Heart attack ☐

Angina / coronary heart disease ☐

Cardiac arrhythmias ☐

Pacemaker ☐

Heart surgery ☐

Infective endocarditis ☐

Valvular heart disease / valve replacement ☐

Stroke *(apoplexy)* ☐

HAVE YOU EVER SUFFERED FROM ONE OF THE FOLLOWING INFECTIOUS DISEASES?

Hepatitis ☐

HIV infection ☐

Tuberculosis ☐

Others: ☐

.....

HAVE YOU EVER SUFFERED FROM ONE OF THE FOLLOWING METABOLIC DISEASES?

Diabetes ☐
If so, treated with insulin? ☐

Liver condition ☐

Kidney condition ☐

Thyroid condition ☐
If so, *overactive* ☐ *or underactive* ☐

Stomach / intestinal diseases ☐

Others: ☐

.....

HAVE YOU EVER SUFFERED FROM ONE OF THE FOLLOWING DISEASES?

Seizure disorders *(epilepsy)* ☐

Depression ☐

Respiratory disease *(chron. bronchitis, asthma)* ☐

Bleeding disorder / treatment with anticoagulants ☐

Glaucoma *(increased intraocular pressure)* ☐

Rheumatism ☐

Tumor ☐
If so, where and since when?

.....

Others: ☐

.....

WOULD YOU LIKE TO BE REMINDED OF YOUR NEXT APPOINTMENT?

by phone ☐

by email ☐

by mail ☐

Kottident

IMPORTANT INFORMATION

We require your health insurance card at every visit in practice. In case it is not presented to us within 14 days after the treatment, we have to consider as a private patient and you will receive an invoice.

Injections (anesthetics) can change responsiveness in a way that your ability to participate actively in traffic or operate machinery is affected. Please plan your visit with the thought in mind that you may not be able autonomously drive a car or ride a bicycle home and take the necessary precautions.

Please bring this completed questionnaire to your appointment with. Should you have any questions, you can contact us here during our opening times:

Kottident
Zahnärztin Anna Wittkopf und Kollegen
Adalbertstraße 94
10999 Berlin
Tel: (+49) (0)30 3911155
www.kottident.de

DECLARATION OF INFORMED CONSENT

Informed consent according to § 73 Abs. 1b Satz 2 SGB V

I hereby agree that the treating dentists at Kottident may obtain findings and reports from other physicians / dentists and are allowed communicate my findings and reports with other physicians / dentists.

I agree to keep scheduled appointments or cancel at least 24 hours in advance, otherwise any costs incurred may be charged according to § 615 Satz BGB §287 ZPO.

I certify the accuracy of the information, and that I have read and understood the printed information.

.....

Signature, Date