BERLIN SMILE
ZAHNZENTRUM

ANAMNESIS

Dear Patient!

Welcome to the Berlin Smile dental clinic. Please complete this questionnaire in order to ensure the best possible dental treatment and care. All of your information will be treated as confidential!

Your reception team

PATIENT

Last name, first name | Date of birth | Place of birth

Address | Postal code, city

Home number | Work number | Mobile

E-mail-address | Occupation, employer

INSURANCE

Health insurance

- ☐ State insurance
- ☐ Private insurance
- ☐ Supplementary insurance
- ☐ European Health Insurance Card
- ☐ Base rate
- ☐ Government (state) benefits

If the insured person is not the recipient of the care, please provide the following information about the insurance holder:

Last name, first name | Date of birth

Address | Postal code, city

HOW DID YOU FIND OUT ABOUT US?

- ☐ Google
- ☐ Jameda
- ☐ Other Internet: _____
- ☐ Personal recommendation
- ☐ While passing by
- ☐ Advertisement: _____
- ☐ Other: _____
- ☐ Refering doctor: _____

BERLIN SMILE ZAHNZENTRUM
HEIDESTRASSE 14
10557 BERLIN

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INFO@BERLIN-SMILE.DE
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CONTINUE

OVERALL HEALTH CONDITION

	yes	no
High blood pressure	☐	☐
Low blood pressure	☐	☐
Hemophiliac	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Cadiovascular disease	☐	☐

If so, which:

Thyroid condition ☐ ☐
Rheumatoid arthritis ☐ ☐
Allergic reactions ☐ ☐

If so, which:

Other diseases:

	yes	no
Infectious disease:		
HIV / AIDS	☐	☐
Hepatitis A, B or C	☐	☐
Tuberculosis	☐	☐

Other:

Medications taken? ☐ ☐

If so, which:

☐ Heart medication:
☐ Cortisone:
☐ Painkillers / Analgesics:
☐ Antidepressants:
☐ Coagulation inhibitors
(e.g. ASS, Marcumar, Heparin):
☐ Other:

Do you smoke? ☐ ☐

If you are female:

Are you pregnant? ☐ ☐

If so, how many weeks?:

ORAL HEALTH

What is the reason for your visit?

☐ Check-up ☐ Consultation ☐ Treatment for pain
☐ New denture ☐ Dental referral ☐ Second opinion
☐ Other:

	yes	no
Are you satisfied with the position, colour and shape of your teeth?	☐	☐
Have you noticed teeth grinding or jaw clenching?	☐	☐
Do you have problems with your gums (e.g. gum bleeding)	☐	☐
Do you suffer from a bad breath or bad taste in mouth?	☐	☐
Do you have an annual professional cleaning of your teeth?	☐	☐
May we remind you of your check-ups and prophylaxis appointments?	☐	☐

Do you have any other questions?

We will gladly remind you of your appointments by SMS.

Please confirm the truthfulness of the health information you have provided with your signature below.

Place, date Signature

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