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. Your personal information is stored electronically in our clinic; It is subject to the statutory data protection regulations (EU General Data Protection Regulation (GDPR), Federal Data Protection Act (BDSG) and medical confidentiality). You can find detailed information about the processing of your personal data in our waiting area.

Your reception team

PATIENT

Gender ☐ m ☐ f ☐ d

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
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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?

For appointments not kept without cancellation, the costs incurred can be invoiced (cancellation fee).
This does not apply in the event of a demonstrably innocent failure to cancel.
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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THANKS