



**DR. OLAF OBERBECKMANN &
DR. KARIN TIETZE**
Zahnarztpraxis

WELCOME TO OUR DENTAL PRACTICE

Before discussing your dental needs and wishes with you, we also require information about your general health in addition to your personal details. This information is important to ensure appropriate treatment with the lowest possible risk. All information is subject to medical confidentiality. **Please print out this form and bring it with you to your first appointment.**

Patient's name:

Date of birth:

Place of birth:

Address:

Phone: Mobile: Work phone:

Email address:

Occupation: Employer:

Employer's address:

Health insurance provider:

For patients with statutory health insurance only:

Compulsorily insured? ☐ yes ☐ no

Voluntarily insured? ☐ yes ☐ no

Private supplementary dental insurance? ☐ yes ☐ no

Have you opted for reimbursement of costs? ☐ yes ☐ no

Insurance details (if different from the patient details)

Invoice to patient or insured person?

Insured person: Date of birth:

Address:

Additional information

Are you interested in regular preventive check-ups to help prevent recurring dental problems? ☐ yes ☐ no

How would you like to be reminded of your next preventive appointment?

☐ by phone ☐ in writing ☐ by SMS ☐ email

Which weekdays and times are most convenient for your appointments?

Weekday: Preferred time:

1. 1.

2. 2.

3. 3.

If I am unable to attend an appointment, I will cancel it at least 24 hours in advance. Otherwise, costs incurred as a result of my absence may be charged to me.



Patient's name:

Before discussing your dental needs and wishes with you, we also require information about your general health in addition to your personal details. This information is important to ensure appropriate treatment with the lowest possible risk. All information is subject to medical confidentiality.

Your Medical History

Heart disease	☐ yes	☐ no	Diabetes	☐ yes	☐ no
Pacemaker / artificial heart valve(s)	☐ yes	☐ no	Thyroid disorder	☐ yes	☐ no
High blood pressure	☐ yes	☐ no	Liver disease (hepatitis)	☐ yes	☐ no
Low blood pressure	☐ yes	☐ no	Stomach / intestinal disorder	☐ yes	☐ no
Tendency to faint	☐ yes	☐ no	Kidney disease	☐ yes	☐ no
Marcumar / anticoagulants	☐ yes	☐ no	Lung disease / asthma	☐ yes	☐ no
Bleeding tendency / bleeding disorder	☐ yes	☐ no	Nasal / sinus disorder	☐ yes	☐ no
Rheumatism	☐ yes	☐ no	Epilepsy	☐ yes	☐ no

Do you have any other serious medical condition? ☐ yes ☐ no

If yes, please specify:

Allergies ☐ yes ☐ no

Which medications do you take regularly?

Are you sensitive or allergic to any medications?

If yes, which medications? ☐ yes ☐ no

Do you smoke?

If yes, how many cigarettes per day? ☐ yes ☐ no

For female patients: Are you pregnant?

If yes, which month? ☐ yes ☐ no

Reason for Your Visit

Routine check-up ☐ yes ☐ no

Other symptoms / requests: