Patient Data Sheet

Klerx + Neumann
Die Prophylaxepraxis

Patient

Family Name ____________________

First Name ____________________

Date of Birth ____________________ Sex male ☐ female ☐

Address

Street Address ____________________

Zip, City, Country ____________________

Home Phone / Cell Phone ____________________

Work Phone ____________________

E-Mail ____________________

Profession ____________________

Insurance ____________________

Company Name ____________________

Referring Physician – Name, Address, Phone ____________________

____

Family Doctor – Name, Address, Phone ____________________

____

If insured person is differing from patient mentioned above please fill in

insured person

Family Name ____________________

First Name ____________________

Date of Birth ____________________

Adress

Street Address ____________________

Zip, City, Country ____________________

Consent of Treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date ____________________

Parent/Legal Guardian Signature ____________________

Please answer the following questions regarding your state of health as exactly as possible

State of Health	Please mark		Further Information
Cardiovascular Diseases			
Hypertension	☐ Yes	☐ No	____________________
Hypotension	☐ Yes	☐ No	____________________
Valvular Heart Disease / Defect	☐ Yes	☐ No	____________________
Endocarditis	☐ Yes	☐ No	____________________
Heart Surgery	☐ Yes	☐ No	____________________
Pacemaker	☐ Yes	☐ No	____________________

Klerx + Neumann Die Prophylaxepraxis | Pelikanstraße 4 | 30177 Hannover | Tel. 05 11 - 70 92 92 | Fax 05 11 - 70 10 217 | www.klerx-neumann.de

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Please answer the following questions regarding your state of health as exactly as possible

State of Health	Please mark	Further Information
Infectious Diseases		
AIDS	☐ Yes ☐ No	______
Hepatitis	☐ Yes ☐ No	______
Tuberculosis	☐ Yes ☐ No	______
other: ______		
Allergies / Intolerances		
Local Anesthetics	☐ Yes ☐ No	______
Analgesics	☐ Yes ☐ No	______
Antibiotics	☐ Yes ☐ No	______
other: ______		
Further Diseases		
Coagulation Diseases	☐ Yes ☐ No	______
Asthma	☐ Yes ☐ No	______
Lung Diseases	☐ Yes ☐ No	______
Thyroid Diseases	☐ Yes ☐ No	______
Rheumatism	☐ Yes ☐ No	______
Epilepsy	☐ Yes ☐ No	______
Diabetes	☐ Yes ☐ No	______
Nephropathy	☐ Yes ☐ No	______
Fainting	☐ Yes ☐ No	______
other: ______		
General Data		
Drug Addiction	☐ Yes ☐ No	______
Drinking of alcoholic beverages	☐ Yes ☐ No	If yes: seldom ☐ often ☐ egularly ☐
Smoker	☐ Yes ☐ No	If yes: 0 – 10 ☐ over 10 ☐ cigarettes / day ______
Regular Medication/Drugs	☐ Yes ☐ No	If yes, since when / Name: ______
X-Rays taken before	☐ Yes ☐ No	If yes, Date / Body Parts: ______
Gravidity / Pregnancy	☐ Yes ☐ No	If yes, what month: ______

How did you get informed about our dentist's practice? ______

______

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Important Information

All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electronically.

I engage myself to inform you immediatelly about all changes occuring during the period of treatment.

I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occuring costs can be invoiced.

I certify with my signature that I have read and understand all above printed information

Date ____

Patient Signature and Parent / Legal Guardian Signature ____

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