Dr. Krasselt
Zahnarztpraxis

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Health sheet

Dear patient,

All information given is subject to medical confidentiality and data privacy requirements and will be handled strictly confidential. You can find information about data privacy in our waiting room. We use the following personal information for medical and organizational purpose. If wanted, you can revoke your personal data.

Personal information

Surname, First name	Date of birth
Street/no.	Postcode/place
Phone (or business)	E-mail (please write clearly)
In case of emergency, please contact (Tel.)	Work/employer
Health insurance/supplementary dental insurance	General practitioner

Please tick or underline where appropriate and, if necessary, complement.

Do you have gum bleeding?	○ yes	○ no
Do you have jaw joint problems, headache or backache?	○ yes	○ no
Do you smoke? If yes, how many daily?_____	○ yes	○ no
Would you like a personal and comprehensive consultation? If yes, which topic?	○ yes	○ no

_____

_____

Do you suffer from any allergies? If yes, which one? (Please show allergy pass.)	○ yes	○ no
Do you have a respiratory disease?	○ yes	○ no
Do you have a seizure disorder, for example epilepsy?	○ yes	○ no
Do you have diabetes?	○ yes	○ no
Do you have a cardiovascular disease?	○ yes	○ no

○ Cardiac insufficiency ○ Heart attack ○ Bypass
○ Heart valve defect/-replacement ○ Pacemaker ○ High blood pressure
○ Insufficient blood circulation in brain/stroke

Do you bleed long after an injury? ○ yes ○ no
Do you take blood thinners? If yes, which one: ○ yes ○ no

Do you have a liver disease? Do you have or had hepatitis? ○ yes ○ no
Do you have an infectious diseases? (HIV, tuberculosis, or similar) ○ yes ○ no
Do you have a kidney disease or reduced kidney function? ○ yes ○ no
Do you have a joint replacement? ○ yes ○ no
Do you suffer from depression? ○ yes ○ no
Do you have osteoporosis? ○ yes ○ no
Do you have or had cancer? ○ yes ○ no
Do you get medication from an orthopedist/oncologist? (bisphosphonates)? ○ yes ○ no
Do you take medication? (please show medication plan) ○ yes ○ no
If yes, which one:

Did you or do you take drugs? ○ yes ○ no
Woman: Are you pregnant? If yes, which month: ○ yes ○ no

Do you have a level of care or a disability? ○ yes ○ no
Do you want brighter teeth? ○ yes ○ no
When was your last dentist appointment?

What are your wishes from our team?

How did you find out about our dental practice?

I hereby confirm that to the best of my knowledge, all the above and attached declarations are complete and correct. Changes are to be communicated immediately.

Chemnitz, _____
Date Signature

Thank you for your help!

Dentist Dr. Cornelia Krasselt, Kathleen Eißmann (Administrative assistant), Steffi Müller (Prophylaxis specialist), Anja Bohne (Dental assistant) and Susanne Markgraf (Dental prophylaxis specialist)