Dr. med. dent. FRANK FRIEDRICH
ZAHNARZT / DENTIST

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Medical history

Dear Patient,

Welcome to the Dr. Frank Friedrich dental practice. Please complete this questionnaire in order to ensure the best possible dental treatment and care. All of your information will be treated in the strictest confidence.

Thank you. Dr. Friedrich & Team

Patient

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

Address | Post code / ZIP code

Phone number

Email address | Occupation, employer

Health Insurance

Please insert above the name of your health insurance provider.

☐ Public insurance
☐ European Health Insurance Card
☐ Private insurance
☐ Basic cover
☐ Supplementary insurance
☐ On state benefits

How did you find out about us?

☐ Personal recommendation
☐ In passing
☐ Advertisement: _____
☐ GP referral
☐ From the Internet: _____
☐ Other (Pls. state): _____

Continue ⇨

Your general health:

Do you suffer from – or have you had – any of the following!

	yes	no
High blood pressure	☐	☐
Low blood pressure	☐	☐
Haemophilia	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Cardiovascular disease	☐	☐

If so, which:
_____

_____

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

If so which:
_____

_____

Other diseases:
_____

_____

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

Other (Pls. state):
_____

Are you currently taking any medication? ☐ ☐

☐ Heart medication:
_____

☐ Cortisone:
_____

☐ Painkillers/ Analgesics:
_____

☐ Antidepressants:
_____

☐ Blood thinners (e.g. ASS, Marcumar, Heparin):
_____

☐ Other:
_____

Do you smoke? ☐ ☐

If you are female:
Are you pregnant? ☐ ☐

Oral health

What is the reason for your visit?

☐ Check-up ☐ Consultation ☐ Treatment for dental pain ☐ Dental referral
☐ Second opinion ☐ Other: _____

Declaration

I declare that the information I have given above is correct to the best of my knowledge.

Place, date Signature