

## ANAMNESIS

### Dear Patient!

Welcome to **torhaus** dental practice. Please complete this questionnaire in order to ensure the best possible dental treatment and care. All of your information will be treated as confidential!

Your reception team

### Patient

Last name, first name		Date of birth	Place of birth
Address		Postal code, city	
Home number	Work number	Mobile	
E-mail-address		Occupation, employer	
Appointment reminder	<input type="checkbox"/> SMS	<input type="checkbox"/> E-mail	<input type="checkbox"/> None

### Insurance

Health insurance

<input type="checkbox"/> State insurance	<input type="checkbox"/> Private insurance	<input type="checkbox"/> Supplementary insurance
<input type="checkbox"/> European Health Insurance Card	<input type="checkbox"/> Base rate	<input type="checkbox"/> 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?

<input type="checkbox"/> Google	<input type="checkbox"/> Jameda	<input type="checkbox"/> Other Internet: _____
<input type="checkbox"/> Personal recommendation	<input type="checkbox"/> While passing by	<input type="checkbox"/> Advertisement: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Referring doctor: _____	

## Overall health condition

	yes	no
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hemophiliac	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>

If so, which:

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Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>

If so, which:

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Other diseases:

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## Oral health

What is the reason for your visit?

<input type="checkbox"/> Check-up	<input type="checkbox"/> Consultation	<input type="checkbox"/> Treatment for pain
<input type="checkbox"/> New denture	<input type="checkbox"/> Dental referral	<input type="checkbox"/> Second opinion
<input type="checkbox"/> Other:		

Are you satisfied with the position, colour and shape of your teeth?

yes no

 

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?

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Please confirm the truthfulness of the health information you have provided with your signature below.

Place, date

Signature