dentisten.berlin
www.dentisten-berlin.de

Medical History

Patient

Last name: | Given name: | Date of birth:

Postal address: ....

Telephone: | Mobile Phone: | Telephone at work:

E-Mail address: ....

Health insurance: | statutory health insurance | Privat insurance:

Insured person (if different):

Last Name: | Given name:

Date of birth: | Postal address: | Telephone:

Mark with a cross where applicable or fill in

Cardiovascular disorders

Heart attack

Heart valve replacement

Endocarditis

Bypass, Stent, Pacemaker

Infectious diseases, Hepatitis, HIV

High blood pressure

Coagulation disorders

Pulmonary diseases, Asthma, COPD

Diabetes

Glaucoma

Rheumatism

Tumors

Osteoporosis

Bisphosphonate therapy

Allergies, which?

Kidney disease

Epilepsy

Pregnancy

Other diseases:

which? ....

Which medication you need to take? ....

....

Would you like to stay informed about our prophylaxis-program?

How did you come to know of us? ....

Date: .... Signature: ....

Your details will be treated with the strictest confidence and are subject to data protection and underlies professional discretion according to § 203 StGB.