LEUTERT
ZAHNÄRZTE

PATIENT INFORMATION

Gender: ☐ Male ☐ Female	Legal representative/assistance:
Last name:	
First name:	
Date of birth:	
Street:	Cost bearer: Self ☐ Health insurance (KVG) ☐ Accident insurance (UVG) ☐ Social welfare office ☐ Asylum Seeker (ORS) ☐ Supplementary payment ☐
ZIP Code:	
Place of residence:	
Telephone private:	
Telephone business:	Health insurer/place:
Mobile phone:	Insurance number:
E-Mail:	Name and adress of your med. doctor:
Profession:	

HOW DID YOU HEAR ABOUT US?

☐ Recommended by:

☐ Medical referral from:

☐ Emergency patient from another practice:

☐ By myself: ☐ Internet/Homepage
☐ Telefonbook
☐ Other reason:

MAIN COMPLAINTS

Please give a brief description for the main reason you are seeking treatment/consultation with us:

Do you suffer from pain in the mouth or head area? yes ☐ no ☐

If yes: where?
since when?
has the pain already been treated?

FURTHER QUESTIONS ON THE BACK ➤➤➤

INFORMATION ON THE GENERAL HEALTH STATUS

		yes	no
1	Were you examined by a doctor during the last year?	☐	☐
2.	Have you ever been seriously ill and/ or treated in a hospital?	☐	☐
3.	Are you currently taking any medication? If yes, which?	☐	☐
4.	Have you ever experienced an unusual reaction (allergy, etc.) to injections, medication or dental materials?	☐	☐
5.	Do you bleed easiliy or for a prolonged time when you injure yourself? Do you take blood thinners (anticoagulants)?	☐	☐
6.	Are you suffering from high/low blood presure?	☐	☐
7.	Are you suffering from a congenital or acquired heart defect?	☐	☐
8.	Do you have a medical card/pass related transplants or joint replacement?	☐	☐
9.	Have you ever had an accident to your face or jaws?	☐	☐
10.	Did you undergo surgery or radiotherapy in these areas?	☐	☐
11.	Are you presently suffering or have you ever suffered from the following diseases?	☐	☐
	a) Diabetes?	☐	☐
	b) Asthma or hay fever?	☐	☐
	c) Epileptic seizures?	☐	☐
	d) Gastric/digestive disorders?	☐	☐
	e) Eczema?	☐	☐
	f) Rheumatism?	☐	☐
	g) Osteoporosis?	☐	☐
	h) Infections (tuberculosis, hepatitis, sexual transmitted diseases, HIV/AIDS)?	☐	☐
	i) Tumor disease?	☐	☐
	j) Emotional disturbaces?	☐	☐
	k) Other:	☐	☐
12.	Do you faint easily?	☐	☐
13.	Do you vomit frequently?	☐	☐
14.	Do you smoke? If yes, how much and for how many years?	☐	☐
15.	Do you consume alcohol or light/hard drugs regularly? If yes, how much?	☐	☐
16.	For females: Are you currently pregnant? Are you breastfeeding	☐	☐
17.	Have you been vaccinated against COVID19?	☐	☐

In the case of a dental referral or order placed with external dentists/physicians or dental technicians, Leutert Zahnärzte may transmit all data necessary for further treatment to the attending dentist/physician or dental technician.
In case of default in payment, i agree that Leutert Zahnärzte can forward the data necessary for debt collection to the respective enforcement and bankruptcy authorities, judical institutions as well as any debt collection agency or legal counsel retained by Leutert Zahnärzte for this purpose.

Date:____________________ Signature:____________________