PATIENT QUESTIONNAIRE

for our EMERGENCY SERVICE - patients

Dear Patient!

You have come to us with a problem during our emergency service and need help. But we also need your support. It is hard to exactly plan everything during emergency service. It is always possible to encounter unpredictable incidents or delays. That is why it is EMERGENCY service.
To provide a smooth-running service nonetheless, we would like you to fill in this questionnaire conscientiously. General illnesses can also affect the dental treatment. All information is of course subject to medical confidentiality. Please read also our privacy policy on our homepage or in the waiting area of our practice.

Yours, Dr. Ralf Voßler & Team

(Pat.-Nr. _____)

Personal patient data

Surname, name of patient | Date of birth

Surname, name of insurant, if not the above | Date of birth

Street | ZIP code, City

Phone private and/or at work | Phone mobile

E-Mail | Profession, Employer

Health plan / sickness fund, in which you - the patient- are insured

Are you supplementarily insured? ja ○ nein ○

Are you as a PRIVATE patient: eligible for benefit ○ or insured in a base rate? ○

If patient (i.e. children) and insurance member are not the same, please add the data of the policyholder.

Surname, name | Date of birth

Street and city, if not the above

Please proceed on the back

www.dr-vossler.de hindenburgstr. 12 37154 northeim 05551-2500 info_praxis_vossler@t-online.de

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General health situation

Do you suffer from

	yes	no		yes	no
High blood pressure	○	○	Low blood pressure	○	○
Bleeding disorder	○	○	Thyroid diseases	○	○
Rheumatic diseases	○	○	Tumor diseases	○	○
Asthma	○	○	Do you smoke?	○	○
Kidney diseases	○	○	Do you have artificial joints?	○	○

Infectional dieseases like:	HIV	○	○	Tuberculosis	○	○
	Hepatitis	○	○	if so, which type:_____		

Diabetes	○	○	if so, which type:_____
Allergies	○	○	if so, which:_____
Cardiac diseases	○	○	if so, which:_____
Have you had an apoplectic stroke?	○	○	if so, when:

Do you take any medication?	○	○	if so, which:_____		
Is this a:			Biphosphonate?	○	○
Pain killer?	○	○	Blood thinner?	○	○
Antidepressant?	○	○	Cortisone?	○	○

Do you have other diseases?	○	○	if so, which:_____	
Did you have surgeries earlier on?	○	○	if so, which:_____	
Did you tolerate dental anesthesia well?			○	○
For our female patients: Are you pregnant?			○	○

Name of your family doctor?_____

Name of your dentist?_____

In urgent cases please contact: _____

With my signature I confirm the correctness of the above mentioned health information, have taken note of the privacy policy and agree with the processing of my personal data in the sense of the privacy policy for patients (see announcement).

Date: _____ Sign:_____

office internal - zur Kenntnis genommen:_____

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