Anamnesis Questionnaire

updent ZAHNÄRZTE

Title ________ Surname __________________________________ First name _______________________________

Date of birth ____________ Insurance no. ____________________ Public health insurance ____________________

Supplementary insurance ____ ☐ m ☐ w

Address ____ ZIP ______ City ____________________

Mobile no. _________________________________ Email ____

Occupation ____________________________________ Employed at _____________________________________

Recommended by __________________________________

Fill in only if..

Legal representative (patient is underage/committed to care)

Assumption of liability as a guarantor/payer for the patient

Title ________ Surname __________________________________ First name _______________________________

Address ____ ZIP ______ City ____________________

Mobile no.: _________________________________ Email ____

The following details shall only serve the optimization of your treatment. We therefore ask you to inform us about any future changes in your health condition and data. All your details are subject to medical confidentiality.

Please tell us the reason for your visit:

☐ Check ☐ Prophylaxis ☐ Dental aesthetics ☐ Refurbishing

☐ Periodontal consultation ☐ Endodontics ☐ Implants ☐ Emergency treatment

☐ Bleaching ☐ Dentist transfer ☐ Other ____

Last visit to the dentist on ______________ Reason for the visit ____

Extraordinary reactions to syringes, medication, or dental materials? ☐ Yes ☐ No

What x-ray images (Maxillofacial area) were taken during the last 12 months? _______________________________

Have you ever had...

☐ a jaw regulation
☐ grind off treatment
☐ a surgery in the jaw/Maxillofacial area
☐ no

Do you have any complaints regarding

☐ gums
☐ chewing ability
☐ jaw/paranasal sinuses
☐ jaw joint
☐ no

Are you satisfied with the

Position	☐ yes	☐ no
Colour	☐ yes	☐ no
Form	☐ yes	☐ no

of your teeth

DR. KARL SCHWANINGER
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Anamnesis Questionnaire

Diseases

- ☐ Cardiovascular diseases
  Which?____________________
- ☐ Pacemaker
- ☐ Blood coagulation disorder
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Immune disease (e.g. HIV)
- ☐ Wound healing disorder
- ☐ Diabetes (sugar disease)
- ☐ Bone marrow diseases
- ☐ Radiotherapy of the jaw bone
- ☐ Osteoporosis
- ☐ Tumor diseases
- ☐ Periodontal treatment
- ☐ Drug abuse
- ☐ Asthma/Lung disease

Diseases

- ☐ Nerve disorders
- ☐ Rheumatic diseases
- ☐ Depression/psychosis
- ☐ Liver diseases
- ☐ Kidney diseases
- ☐ Epilepsy
- ☐ Gastrointestinal diseases
- ☐ Hepatitis
- ☐ Serious accident with loss of consciousness
- ☐ Other:

____

- ☐ Radiotherapy
- ☐ Chemotherapy

Do you take any medication?

- ☐ for blood thinning
- ☐ against cancer
- ☐ against osteoporosis
- ☐ generally:___________________
- ☐ currently:___________________
- ☐ none

Do you smoke

- ☐ Yes, How much?____ Since____
- ☐ Not anymore; Since____
- ☐ No, never smoked

For female patients - pregnant:

- ☐ No
- ☐ Yes; month: ________________

- I am informed that updent – Dr. Karl Schwaninger & Konsiliarärzte is a private dental practice without a public health insurance contract.
- I give my express consent that in case of a medically indicated expediency, Dr. Karl Schwaninger or another doctor working at this private dental practice are allowed to request medical results (including x-rays etc.) concerning the patient from third parties.
- I understand that the private dentist practice reserves its right to charge the patient for any costs resulting from untimely cancellation (at least 48 hours in advance) of previously agreed appointments without a particular reason.
- I have been made aware that my fitness to drive a car under the influence of injections as well as medication given to me before or during the treatment might be affected for up to 4-6 hours.
- I give my consent that the data collected during the treatment can be used (anonymously) for scientific research and presentations.
- It is agreed that the place of jurisdiction shall be the District Court of Josefstadt.
- I hereby confirm the correctness and completeness of the above information.

Date ________________ Signature ____

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