Questionnaire

Leo Dental

Dear patient, a warm welcome to our dental practice.
It is our goal to always offer you the best possible treatment. Therefore we kindly ask you to fill out this form thoroughly. It helps us to provide you with the best possible care.
Privacy protection is ensured at all time by medical confidentiality and German law.

In case you should need assistance filling out this form, please do not hesitate to ask us.

Patient

Name	Surname		Date of birth
Residential adress	ZIP Code	City	Country
Phone	Email		

Insurant / payer

Name	Surname		Date of birth
Residential adress	ZIP Code	City	Country
Phone	Email		
Profession	Employer		

Health insurance company

Insurance _____

- ☐ Do you have a voluntary health insurance?
- ☐ Are you socially insured?
- ☐ Are you privately insured?
- ☐ Do you have supplementary dental insurances?

How did you learn about our dental practice?

- ☐ Personal recommendation
- ☐ Google search
- ☐ Google maps
- ☐ facebook
- ☐ Internet others
- ☐ Yellow pages
- ☐ Medical rating page (e.g. Jameda)
- ☐ Random / neighbourhood

Please turn page

Questionnaire

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Do or did you suffer from any of the following diseases?

- ☐ no ☐ yes Asthma
- ☐ no ☐ yes Allergic reactions (e.g. hay fever)
- ☐ no ☐ yes Intolerance to the following medication and material (e.g. iodine, penicillin)
  _____
- ☐ no ☐ yes Documentation form about the allergy?
- ☐ no ☐ yes Do you take any medication currently or regularly? If yes, please specify:
  _____
- ☐ no ☐ yes Icterus, liver diseases
- ☐ no ☐ yes Kidney disease
- ☐ no ☐ yes Diabetes
- ☐ no ☐ yes Epilepsy
- ☐ no ☐ yes Diseases of blood: bleeding disorder hemophilia? anemia?
- ☐ high ☐ low High or low blood pressure? (Please mark)
- ☐ no ☐ yes Do you take blood clotting inhibitors?
- ☐ no ☐ yes Disease of thyroid gland
- ☐ no ☐ yes Cardiovascular diseases cardiac insufficiency?
- ☐ no ☐ yes Angina pectoris (stenocardia)?
- ☐ no ☐ yes Pacemaker?
- ☐ no ☐ yes Hepatitis
- ☐ no ☐ yes HIV
- ☐ no ☐ yes Depressions

☐ no ☐ yes Pregnancy? Week: _____

My general practitioner _____

Others: _____

In case you should not be able to keep the appointment, please notify us at least 24 hours in advance. We will be happy to make a new appointment. Should you not cancel the appointment within sufficient time in advance, please note that compensation charges might apply. In case of an emergency please allow a short waiting time.

declaration of consent for processing personal patient data according to Art. 6, 7 Abs. 1 DSGVO of 25.05.2018: I herewith agree to the storing and processing of my personal data by the practice. I was informed on my option to revoke this consent at any time in written form or via email to the practice (Art. 7 Abs. 3 DSGVO). I am aware that my otion to revoke does not affect the time during consent and revocation (Art. 7 Abs. 3 Satz 2 DSGVO).

I herewith confirm that I answered this questionnaire completely and to the best of knowledge.

Please remind me of my next regular check up.

☐ no ☐ yes

City, Date

Signature of patient / guardian