Dental Office of Dr. med. dent. Michael Wolf & Colleagues
Dentist · Implantology · Periodontics

Patient Information – Case History

We need this information to give you the best treatment.
We want to give you the best possible help. To do this, first of all we need some information about you. We therefore ask you to answer the following questions as accurately as you can and to check everything that applies to you – please take some time to do this. Of course your details will be treated with the strictest confidence and will not be passed on to third parties.

Personal details

Surname _____ First name _____

Date of birth _____ Health insurer (e.g. for children) _____

Street, no. _____ ZIP code _____ Town/city _____

Telephone _____ Email _____

Occupation _____

Health insurer _____

❑ Voluntary health insurance ❑ Entitled to subsidies ❑ Basic tariff, private health insurer

How did you find out about us?

❑ Recommendation. Who recommended us? _____

❑ Our dental office website

❑ General Internet research

❑ Telephone directory / Yellow Pages / similar

❑ Other (please specify) _____

Reason for your visit to our dental office

_____

_____

_____

Do you have any of the following?

❑ Pain

❑ A particular problem. Please specify _____

How can we help you? (Please check any that apply)

❑ Consultation/advice

❑ Routine check-up

❑ All-round examination

❑ Repairs

❑ Replacing amalgam fillings

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Please contact us for an appointment · www.zahnarzt-dr-wolf.de

Dental diseases or symptoms (please check any that apply)

- ❑ Bleeding gums ❑ Occasionally ❑ Frequently
- ❑ Pain on opening the mouth, yawning or chewing
- ❑ Do you press your teeth together or grind them?
- ❑ Bad breath (halitosis)
- ❑ Do you have side-effects from dental injections?
  Please specify _____
- ❑ Other diseases _____

General diseases or symptoms (please check any that apply)

- ❑ Frequent stress
- ❑ Circulatory problems
- ❑ Liver disease (hepatitis)
- ❑ Kidney disease
- ❑ Asthma
- ❑ Rheumatism
- ❑ Chronic respiratory problems
- ❑ Tendency to bleed or blood clotting disorders
- ❑ Do you have low blood pressure?
- ❑ Do you have high blood pressure?
- ❑ Do you have a cardiac pacemaker?
- ❑ Other diseases
- ❑ Heart disease
- ❑ Diabetes
- ❑ HIV
- ❑ Tuberculosis
- ❑ Gastric disease
- ❑ Epilepsy
- ❑ Stroke
- ❑ Earache
- ❑ Tinnitus
- ❑ Do you have tension in your neck or headaches?
  ❑ Occasionally ❑ Frequently

_____

_____

_____

Previous and current treatment by a physician (please check any that apply)

- ❑ Have you ever been treated for periodontitis? When? _____
- ❑ Have you ever had professional dental cleaning?
- ❑ Have your teeth been x-rayed within the last year?
- ❑ Do you have an x-ray pass?
- ❑ Are you receiving orthopedic treatment or physiotherapy?
- ❑ Are you currently being treated by a physician?
- ❑ Are you taking any regular medication? If so, what?

_____

_____

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Name and address of your general practitioner

_____

_____

Desired appearance (please check any that apply)

❑ Whitening yellow teeth
❑ Replacement of dark-colored fillings
❑ Visual correction of misaligned teeth

Oral hygiene (please check any that apply)

❑ Do you use dental floss or any other dental aids to look after your teeth? What do you use?

_____

How often? ❑ Regularly ❑ Occasionally ❑ Rarely

❑ Do you want to have your teeth cleaned professionally on a regular basis?
❑ Do you have some teeth that are especially sensitive to temperature?
❑ Do you have some teeth that are especially sensitive to biting?

Important information:
I have hereby been informed that my ability to drive in road traffic may be restricted under the influence of local anesthetic injections, therapeutic injections and medications that I receive before and during my treatment, for a period of four to six hours after the treatment.

Furthermore, I have been informed that appointments are reserved for me at the times agreed. Therefore it is essential to keep appointments that have been made. If I cannot keep an appointment I must cancel with at least 24 hours' notice. Appointments that are not kept will have to be billed.

Town/city _____ Date _____

Signature _____

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