Dr. med. dent. Anne Kathrin
KLOTH
ZAHNÄRZTIN

Dear patient!

Illness and diseases of all kinds can have an effect on your dental treatment. For this reason, we ask you to please complete this questionnaire with care. It serves as a basis for preparing for your appointment and will be attached to your file card. It goes without saying that the information you provide is subject to complete doctor-patient confidentiality.
We will be glad to help you if you need any assistance with the individual questions and would like to thank you for your kind cooperation.

1. Personal details:

Your name: _____ First name: _____
Born on: _____ Profession:_____
Street: _____ Postal code: Town: _____
Private phone no.: _____ Mobile phone no.:_____
General practitioner: Name, address:
_____

Name of the insured party:_____ First name: _____
Born on:_____
Street:_____ Postal code:_____

How did you find out about our practice? Who recommended our practice to you? Internet O Advertisement O Recommendation O _____

2. Questions about your health:

Allergies	Yes **o**	No **o**	Which? _____	
Seizures/Epilepsy	Yes **o**	No **o**		
Respiratory disease	Yes **o**	No **o**		
Bleeding disorders	Yes **o**	No **o**		
Diabetes	Yes **o**	No **o**	Type? _____	
Glaucoma/Ocular hypertension	Yes **o**	No **o**		
Hematologic disorders	Yes **o**	No **o**	Are you fitted with an artificial	
Cardiovascular diseases	Yes **o**	No **o**	prosthesis, e.g. a hip joint?	Yes **o** No **o**
Cardiac degeneration	Yes **o**	No **o**	Infectious diseases	Yes **o** No **o**
Coronary heart disease/			Immune deficiency syndrome/AIDS	Yes **o** No **o**
Angina pectoris	Yes **o**	No **o**	Liver (jaundice, hepatitis)	Yes **o** No **o**
Heart attack	Yes **o**	No **o**	Gastrointestinal disorders	Yes **o** No **o**
Cardiac arrhythmias	Yes **o**	No **o**	Kidney diseases	Yes **o** No **o**
Pacemaker	Yes **o**	No **o**	Osteoporosis	Yes **o** No **o**
Heart valve defect/replacement	Yes **o**	No **o**	Rheumatoid arthritis	Yes **o** No **o**
Hypertension/High blood pressure	Yes **o**	No **o**	Thyroid disease	Yes **o** No **o**
Hypotension/Low blood pressure	Yes **o**	No **o**	Tumour diseases	Yes **o** No **o**
Do you smoke?	Yes **o**	No **o**		
Pregnancy	Yes **o**	No **o**	If yes, in which month? _____	
Do you wear dentures?	Yes **o**	No **o**		
If yes:	fixed ☐ Implant(s) ☐ Removable ☐			

Other illnesses/diseases:

Regular medication, especially for blood thinning or for your bones (what are known as bisphosphonates):

Past operations:

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In any changes take place in your state of health, please inform us immediately. By signing the second page, you confirm the completeness and accuracy of the information you have provided about your health.

Please also note that each appointment at our practice is scheduled individually. For this reason, we would like to ask you to cancel at least 48 hours in advance if you are prevented from attending.

3. Questions about your insurance

Do you have private supplementary insurance for dental treatment? Yes **o** No **o**

If you are privately insured: Do factoring limits apply to you? Yes **o** No **o**

Dental treatment frequently gives rise to costs.
For this reason, we would like to ask if you are interested in entering into an instalment payment plan ?

4. Your wishes with regard to planning your dental treatment

We can provide you with almost every known modern dentistry treatment option at our practice. What is also especially important to us, dear patient, is establishing a good human relationship with you. The answers you give below make it easier for us to provide you with individual advice and treatment.

What are your reasons for visiting our dental practice?

_____
_____

What do you want from your future dental practice?

_____
_____

What are your long-term wishes for your dental health?

_____
_____

Thank you in advance for taking the time to answer these questions.
The Practice Team

_____ _____
Town/Date Patient's signature

Dr. Anne Kathrin Kloth, Tibarg 1b, D-22459 Hamburg