

MEDICAL HISTORY

We are very pleased to welcome you to our practice.

We kindly ask you to fill out this form conscientiously so that we can fulfil your wishes as best as possible. General illnesses can also have an impact on dental treatment.

All information is of course subject to medical confidentiality.



JACOB & JACOB
DENTAL CARE BERLIN

Patient Data

<input type="text"/>		<input type="text"/>
Name, First Name		Date of birth
<input type="text"/>		<input type="text"/>
Street, no.		Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone mobile	Phone landline	Phone work
<input type="text"/>	<input type="text"/>	
E-mail	Occupation/employer (this information is important for our BFS computer centre)	

- ☐ Yes, the practice may revocably use my email address and mobile phone number for direct communication with me (e.g. appointment reminders).
- ☐ E-mail ☐ Mobile number

Insurance

Health insurance ☐ statutory insurance ☐ private insurance ☐ allowance ☐ supplementary insurance

Bonus booklet: ☐ 5 years in a row ☐ 10 years in a row

If patient and member of the insurance are not identical, please complete the data of the policyholder:

<input type="text"/>	<input type="text"/>
Name, First Name	Date of birth
<input type="text"/>	<input type="text"/>
Street, no.	Zip code

General health information

Please answer the following questions about your health.

Cardiovascular diseases:

- ☐ High blood pressure (hypertension)
- ☐ Low blood pressure (hypotension)
- ☐ Heart valve disease/defect
- ☐ Heart surgery
- ☐ Pacemaker
- ☐ Angina pectoris
- ☐ Other: _____

Respiratory diseases:

- ☐ Chronic bronchitis
- ☐ pneumonia ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ Snoring
- ☐ Sleep apnoea
- ☐ Other: _____

Infectious diseases:

- ☐ HIV
- ☐ Hepatitis A / B / C
- ☐ Tuberculosis
- ☐ Other: _____

Eye diseases:

- ☐ Glaucoma
- ☐ Cataract
- ☐ Severe reduction of vision
- ☐ Blindness
- Sonstiges: _____

Allergies/intolerances:

- ☐ Local anaesthetics, which ones: _____

Allergies/intolerances:

- ☐ Painkillers/antibiotics, which: _____
 - ☐ Iodine
 - ☐ Allergy passport
- (please hand in for copying!)**

Vascular diseases:

- ☐ Stroke
- ☐ Varicose veins
- ☐ Circulatory disorders
- ☐ Thromboses
- ☐ Other: _____

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General health information

Please answer the following questions about your health.

Other diseases:

- ☐ Blood coagulation disorders
- ☐ Kidney dysfunction/dialysis
- ☐ Thyroid disease
- ☐ Fainting tendency
- ☐ Cancer, where/what: _____
- ☐ Other: _____
- ☐ Rheumatism
- ☐ Epilepsy
- ☐ Diabetes mellitus ☐ type 1 / ☐ type 2

General information:

☐ Regular medication, if yes, please specify with exact name: _____

☐ Smoker, if yes how many cigarettes/day: _____

☐ Alcohol consumption, if yes how often: _____

☐ Drug use _____

General:

☐ Have you had an X-ray of your head, jaw and teeth in the last year? If yes: date/part of body: _____

☐ Pregnancy, if yes which month: _____

Clarification

Information about dental local anaesthesia

Dental local anaesthesia (local anaesthesia) serves to locally eliminate the sensation of pain in the area of the teeth, mouth, jaw and face. It enables the necessary treatments (such as fillings, root canal treatments, extractions, operations) to be carried out without pain as a rule. This region of the body is mainly supplied with sensation by the trigeminal nerve (a cranial nerve). To anaesthetise this, the local anaesthetic solution is placed as close as possible to the smaller nerve fibres (infiltration anaesthesia) in the periodontium and jawbone (intraalveolar anaesthesia) or near one of the three main branches of the nerve (conduction anaesthesia). Although local anaesthesia is a safe procedure for eliminating pain, side effects and intolerances of the substances that can be used are not necessarily avoidable.

The following complications may occur, among others:

Haematoma (bruise): Small blood vessels can be injured by the injection, causing bleeding. If the masticatory muscle is affected, this can lead to an obstruction in the opening of the mouth and pain. In very rare cases, infections can also occur, in which case you should inform your dentist immediately! As a rule, there is a complete recovery of all functions.

Self-injury: <As long as the anaesthetised state (e.g. tongue, cheeks, lips) persists, please refrain from eating, as burns and frostbite are possible in addition to bite injuries. Trafficability: As a result of the local anaesthetic and the dental treatment, the ability to react and concentrate may be impaired. This can be attributed to the stress and anxiety associated with the treatment as well as local irritation. You should therefore not actively participate in road traffic during this time.

Declaration of consent for dental local anaesthesia

☐ I have understood the information provided. My questions have been answered to my satisfaction.

☐ I have no further questions..

Important note: Please inform us of any change in your state of health without being asked before further treatment appointments!

We always strive to save you long waiting times, so we schedule treatment times that are provided just for you. If you do not keep your appointment, there will be idle time in our practice. Therefore, if you are unable to attend, we ask that you give at least 24 hours notice to cancel any scheduled appointments, and at least 48 hours notice for appointments scheduled for 2 hours or longer. We are entitled to charge for appointments that are not kept according to the time spent and the treatment planned.

Please bear in mind that patients who visit us in pain have to be integrated into the appointment system - this can lead to time delays in rare cases. You will then be informed immediately. Please have understanding for this.

Declaration of consent under data protection law

for the processing of personal patient data in accordance with Art.6, 7 Para. 1 lit. a DSGVO. I agree to the storage of my personal data for the purpose of treatment by the practice. The information on the collection of personal data can be viewed in the practice. Please confirm the correctness of your health information and consent with your signature

Place, date

Signature