DR. FRANK MÜLLER
Praxis für Zahnheilkunde

Patient Data Sheet

Last name: First name: Birth name: Birthplace: street: zip code/town: Born on: Telephone (private) : (work) : Health insurance: Profession/employer: Family doctor/address: Family doctor/telephone	*If the patient and the insured person are not identical, please also give the following information* name, first name of the insured person street: city code/place: born on: Insurance:

Please answer the questions below regarding your current health situation as exactly as possible!

The information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and are treated strictly confidential.

heart/cardiovascular diseases:			**infectious diseases:**			**allergies or intolerances:**		
hypertension	yes	no	AIDS	yes	no	local anesthetics	yes	no
valvular defect	yes	no	hepatitis	yes	no	antibiotics	yes	no
cardiovalvular replacem.	yes	no	tuberculosis	yes	no	analgesics	yes	no
pacemaker	yes	no				metals:		
endocarditis	yes	no						
operation on the heart	yes	no						
convulsive disorders (epilepsy)	yes	no						
asthma/lung diseases	yes	no				drug addiction	yes	no
coagulation diseases	yes	no				diabetes	yes	no
fainting	yes	no				nephropathy	yes	no

other diseases:

Are you pregant? yes no If yes, which month? .....
Were dental X-rays of you taken before? yes no If yes, when .....
Which medicines do you take regularly or at the moment? .....
Since when ..... I engage myself to inform you immediately on all changes occuring during the total period of treatment. Furthermore, I engage myself to keep agreed appointments, or to cancel them at least 24 hours in advance. Appointments which have not been cancelled can be invoiced. I agree to my data being stored and processed electronically.

...Neuss ..... signature: .....
date

Should you have any further questions, please let us know
We are here for you!