ZAHNARZTPRAXIS
Dr. Evelyn Diensthuber

Health Survey

Surname, Name: ____ Date of Birth: ____________________

Address: ____

Telephone Number: _______________________________________ Tel. Nr. Work: ___________________

e-Mail: ____

General Practitioner: ____

Health Insurance: ____

Occupation / Employer: ____

Who recommended us? ____

*If **you are not** member of a health insurance, who is the assured person?*

Surname, Name: ____ Date of Birth: ____________________

General Health Anamnesis

Because of which medical conditions are you/ were you under medical treatment in the last 2 years?

____

Which surgeries did you undergo in the last 5 years, especially in the mouth and head region?

____

Which allergies or intolerances do you have?

____

Which medication or nutritional supplement do you take on a regular basis?

____

Are you pregnant? O Yes / O No If so, which week are you in? ____________________

Do you smoke? O Yes / O No If so, how much? ____________________

Are we allowed to take pictures of your mouth region and teeth? O Yes / O No

Are you scared of the dental treatment? O Yes / O No

Do you want to be reminded of your annual checkup? O Yes / O No

Date, Signature: _________________ ____