DENTAL EAST
DR. MARC VOLLERT

Dear Patient,
Welcome to your dental health practice.

We want to make your experience at the practice as pleasant as possible.
To create your personal treatment file and in the interest of treatment without complications, we need some information from you. Please answer the following questions completely and correctly.
If you have any questions, we are of course happy to help.

Patient

Name | First Name

Birth name | Birth place/country | Date of Birth

Member

Name | First Name

Birth name | Birth place/country | Date of Birth

Address

House number, street | Postcode/City

Private telephone | Mobile

Daytime telephone | Email

Health insurance company/private insurance

Name

Statutorily insured ☐ Voluntarily insured ☐ Private insurance ☐ Additional insurance ☐

eligible to receive benefits ☐ exempt from co-payment ☐ As a private patient, I have only taken out a basic tariff ☐

Occupation | Employer

Your GP

Your primary concern

Would you be interested in alternative medical therapy support? Yes ☐ No ☐

How did you hear about our practice?

May I inform you by email about dental health news and/or news from my practice? Yes ☐ No ☐

Appointment-based practice

As we are an appointment-based practice, we ask you to make every appointment with us by phone, online or in person. We assign each appointment only once and then really have the time for you that we need. Please understand that we have to charge according to the private fee regulation (GOZ) for appointments that have not been cancelled 24 hours in advance.

Please also fill in the reverse side.
Many thanks.

Information about health

Holistic dentistry is based on the simple idea that the cause of many acute and chronic diseases lies in the mouth. On the other hand, more common illnesses can also have an impact on dental treatment. Therefore, we ask you to answer the following questions about your health. All information is subject to medical confidentiality and will be treated in strict confidence.

Do you have the following diseases?	Yes	Which?	No
Cardiovascular diseases, pacemaker:			
Infectious diseases (hepatitis, HIV, TB or other):			
Blood clotting disorders, take e.g. Macumar:			
Allergies / hypersensitivities (hay fever, asthma, certain medications, other):			
Do you have orthopaedic disorders?			
Internal diseases:			
Diabetes/osteoporosis:			
Do you smoke?		How much?	
Are you currently taking medication, e.g. bisphosphonates?			
Are you currently pregnant?			
Other (e.g. tinnitus, migraine):			
Date of the last X-ray examination:		Your teeth	
Do you have jaw joint complaints (cracking, rubbing)?			
Do you have masticatory muscular complaints (restricted mouth opening, feeling of tension)?			

Information and special requests for treatment

Would you like to be informed about an intensive prevention (prophylaxis) programme to avoid caries and periodontosis?	Yes		No	
Do you notice any gum disease? Gum bleeding?	Yes		No	
Are you satisfied with the position, colour, shape of your teeth?	Yes		No	
Do your rows of teeth fit together properly?	Yes		No	

Would you like advice about

Splint therapy		Cosmetic dentistry		Gum treatment		Teeth whitening/bleaching	
Teeth implants		TMJ treatment		Alternative oral health		Dentures	
Filling therapy		Periodontosis treatment		Other			

Made it! Thank you for answering all the questions carefully.

Date	Signature

With your signature you confirm the completeness and correctness of your information.