DR. RALF QUIRIN
DR. STEFAN SCHULTHEIS
PRAXIS FÜR ZAHNMEDIZIN

Last name	Email address
First name	Profession
Birth date	Employer
Address	Legal guardian
Postal code / City / Country	Legal guardian's address
Private telephone	
Mobile telephone	Primary physician
Business telephone	Health insurance company

Health questions

	yes	no
Were you recently sick, under the treatment of a doctor, or in the hospital?	☐	☐
Have you ever had a serious illness or operation? If yes, please specify.	☐	☐
Do you regularly take medicine? If so, which medicine(s)?	☐	☐
Are you or have you been taking bisphosphonates (to treat osteoporosis or tumor diseases)?	☐	☐
Do you smoke or have you smoked in the past? If yes, how much?	☐	☐
Have you even had an unusual reaction to injections or medications?	☐	☐
Do you bleed a substantial amount after an injury?	☐	☐
For women: Are you pregnant?	☐	☐

Do you suffer or have you suffered from any of the illnesses listed below?

- ☐ Allergies. Do you have an allergy ID?
- ☐ Cardiovascular disease, heart failure
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Liver or kidney disease
- ☐ Stomach and intestine disease
- ☐ Respiratory and lung disease
- ☐ Epilepsy
- ☐ Osteoporosis
- ☐ Rheumatism
- ☐ Infectious diseases (jaundice, hepatitis, HIV, tuberculosis))
- ☐ Unlisted diseases:

Recommended by: ______________________

Referred by: ______________________

Recall system for disease prevention

We would like for you to be a part of our recall system for disease prevention to guarantee the success of our dental treatment in the long term.

☐ Yes, I would appreciate this service. Please inform me of upcoming appointments via ☐ email ____________ email address

☐ text/SMS ____________ mobile telephone

Patient Agreement

All information here is covered by the discretion agreement and the rules of data protection and will be treated strictly confidentially.
I agree for you to store my personal data.
I will let you know right away if my state of health changes.
I agree to stick to set appointments or to cancel my appointment two days in advance. If I do not do so, resulting costs can ensue. I consent that you may send my data to authorized institutions for the purposes of invoicing, money collecting, and bookkeeping alone. Photos and x-ray pictures can be used for talks and publications.

Place / Date ____________ Signature ____________

Thank you!

DR. RALF QUIRIN
DR. STEFAN SCHULTHEIS
PRAXIS FÜR ZAHNMEDIZIN

Full Name	Birthdate	Date

How would you rate your oral health? ☐ Very good ☐ Good ☐ Okay ☐ Bad

Date of your last oral health screening: ____________

Date of the last oral x-ray: ____________

Have you ever had a professional tooth cleaning? ☐ Yes ☐ No

I visit my dentist every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ not regularly

Reason for your current visit: ____________

Personal Background

	yes	no
Are you anxious about dental health treatment? Scale of 1 to 10 (very) ______	☐	☐
Have you had a negative experience at the dentist?	☐	☐
In the past, have you ever had problems after a dental appointment?	☐	☐
Have you ever had a retainer or an orthodontic treatment or has your bite ever been corrected?	☐	☐
Have you had teeth removed?	☐	☐

Gums

	yes	no
Do your gums bleed when you brush your teeth or when you floss?	☐	☐
Have you ever been treated for periodontitis or has someone talked with you about bone loss?	☐	☐
Have you ever noticed an unpleasant taste or smell in your mouth?	☐	☐
Do you have a family history of periodontitis?	☐	☐
Have your gums ever receded?	☐	☐
Have your teeth ever become loose without an injury or do you have problems when you bite into an apple?	☐	☐
Do you have gaps between any of your teeth?	☐	☐

Dental structure

	yes	no
Have you had cavities in the last three years?	☐	☐
Does it feel like there isn't enough saliva in your mouth or do you have problems swallowing food?	☐	☐
Are some of your teeth sensitive to biting or to hot, cold or sweet things? Furthermore, do you avoid cleaning a part of your mouth?	☐	☐
Do your teeth have grooves or nicks close to your gum line?	☐	☐
Have you ever had a toothache, a broken filling, or a cracked or fractured tooth?	☐	☐
Does food get stuck between your teeth?	☐	☐

Bite and Jaw Joint

	yes	no
Do you have problems with your jaw joint? (pain, noise, lockjaw, or creaking)	☐	☐
Is it difficult for you to chew hard food?	☐	☐
Have your teeth changed in the last five years; did they get shorter, thinner or worn down?	☐	☐
Do you press your teeth together during the day?	☐	☐
Do you have sleeping problems or do you wake up with a tense feeling in your head?	☐	☐
Do you wear a mouth guard at night or have you ever worn one?	☐	☐

Aesthetics

	yes	no
Do you feel self-conscious about how your teeth look?	☐	☐
Have you ever had your teeth whitened (bleached)?	☐	☐
Have you ever been disappointed with the appearance of a dental restoration?	☐	☐
Is there something about the appearance of your teeth which you would like to change?	☐	☐

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