Dr. Susanne M. Hillenbrand
Dentist

Welcome to our practice!

Before we discuss your dental wishes, we need information about your general state of health in addition to your personal details. This is important for adequate and risk-free treatment. All information is subject to medical confidentiality.

Patient
Mr. / Ms. / Child _____

Surname | First name | Place & Date of birth

Member _____

No input is required if you are the patient

Address _____

Street | No. | Landline Number

_____

ZIP Code | Location | Mobile number

Name of Health insurance _____

Profession / Employer _____

Tel. business

For patients with National Health Insurance
We require your health insurance card each time you visit the practice. If it is not available to us even 14 days after treatment, we will consider you as a private patient and you will receive a GOZ (Fees for Dentists) invoice.

Recall for patients
Would you like to take advantage of our free, semi-annual recall service? Would you like us to remind you by letter every 6 months about the next preventive checkup / prophylaxis session with professional tooth cleaning (PZR)?

☐ yes
☐ no

About the organization
We always try to avoid long waiting times. Therefore, we ask you to cancel fixed appointments at least 24 hours in advance if you are unable to attend.

Declaration of consent under data protection law according to Art. 6 para. 1 letter a), Art. 7 DSGVO
I hereby consent to the storage of my personal data for the purpose of my dental treatment by the practice of Dr. S. Hillenbrand.

I have been informed that I may revoke this consent at any time in writing or by e-mail to the practice (Art. 7 para. 3 DSGVO).

I am aware that my revocation of consent, which is possible at any time, does not affect the lawfulness of the processing carried out based on the consent until revocation (Art. 7 (3) sentence 2 DSGVO).

Place, date _____ Signature _____

Please also fill in the back side →

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Admission form

(Please mark yes or no in each line as applicable)

Medical treatment:	Are you currently receiving medical treatment?	☐ yes	☐ no
	If yes, for which illness? _____		
Family doctor / specialist:	Name, address and telephone number: _____		
Medication:	What medications do you take regularly? _____		
	_____		
Allergies:	What materials or medications are you suspected of being allergic to?		
	_____		
	Do you have an allergy passport? If yes, please present it!	☐ yes	☐ no
Heart diseases:	Heart insufficiency	☐ yes	☐ no
	Irregular heartbeat (arrhythmia)?	☐ yes	☐ no
	Cardiac asthma, angina pectoris?	☐ yes	☐ no
	Pacemaker, heart valve replacement?	☐ yes	☐ no
	Other? _____		
Circulatory diseases:	Too high blood pressure?	☐ yes	☐ no
	Too low blood pressure?	☐ yes	☐ no
	Condition after heart attack?	☐ yes	☐ no
	Are you taking anticoagulant medication?	☐ yes	☐ no
	Other? _____		
Vegetative diseases:	Fainting spells?	☐ yes	☐ no
	Do you take stimulants or sedatives?	☐ yes	☐ no
	Other? _____		
Metabolic diseases:	Diabetes?	☐ yes	☐ no
	Gastrointestinal disorders?	☐ yes	☐ no
	Thyroid disease?	☐ yes	☐ no
	Other? _____		
Nervous system diseases:	Epileptiform seizures/epilepsy?	☐ yes	☐ no
	Cramps?	☐ yes	☐ no
	Other? _____		
Blood diseases:	Bleeding tendency (hemophilia)?	☐ yes	☐ no
	Anaemia?	☐ yes	☐ no
	Other? _____		
Infectious diseases:	Liver inflammation/ jaundice (Hepatitis A/B)?	☐ yes	☐ no
	Tuberculosis?	☐ yes	☐ no
	Chronic respiratory diseases, cough etc.)	☐ yes	☐ no
	Have you been vaccinated against covid-19?	☐ yes	☐ no
	Have you had a covid-19 infection?	☐ yes	☐ no
	If yes, when? _____		
Other information:	Are you addicted to drugs or alcohol?	☐ yes	☐ no
X-ray:	Has any x-ray been taken of your head-jaw-dental-area in the last year?	☐ yes	☐ no
	If yes, where? _____		
For Women:			
Pregnancy:	If yes, in which month? _____		

Thank you for your assistance!
Important note: Please inform us about changes in your health condition before the next treatment!

Place, date _____ Signature _____