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 information helps us provide safe and appropriate treatment.

All information is confidential.

Patient
Mr. / Ms. / Child _____

Surname | First name | Place & Date of birth

Health insurance provider / insurer _____

Dental additional insurance _____ **since** _____

I am insured separately ☐ I am covered under _____

Address _____

Street | No. | Landline

ZIP Code | Location | Mobile

Profession / Employer _____

Tel. business

For patients with public 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

Notice regarding scheduling / appointments
I hereby give my consent to receive SMS reminders about my treatment appointment. We always aim to keep waiting times to a minimum. Therefore, we kindly ask you to cancel scheduled appointments at least 24 hours in advance if you are unable to attend. In the event of late cancellations (on the day of treatment) or missed appointments without notice, we reserve the right to charge a cancellation fee in accordance with Section 615 of the German Civil Code (BGB).

Data protection consent declaration pursuant to Art. 6(1)(a) and Art. 7 GDPR
I hereby consent to the storage and processing of my personal data by Dr. S. Hillenbrand's practice for the purpose of my dental treatment. I have been informed that I may withdraw this consent at any time in writing or by email to the practice (Art. 7(3) GDPR). I understand that withdrawing my consent does not affect the lawfulness of processing carried out on the basis of my consent prior to its withdrawal (Art. 7(3), sentence 2 GDPR).

For data protection reasons, please do not submit the completed form by email. Please print it out and bring it with you to your appointment.

Medical history form

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

Medical treatment:	Are you currently receiving medical treatment?	☐ yes	☐ no
	If yes, what for? _____		
Family doctor / specialist:	Name, address: _____		
	_____		
Medication:	What medications do you take regularly?		
	_____		
	_____		
Allergies:	What materials or medications are you suspected of being allergic to?		
	_____		
	Do you have an allergy card? 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
Circulatory diseases:	Too high blood pressure?	☐ yes	☐ no
	Too low blood pressure?	☐ yes	☐ no
	Condition after heart attack?	☐ yes	☐ no
Blood thinning:	Do you take blood thinners?	☐ yes	☐ no
	If yes, which one? _____		
	Do you regularly take sleeping medication or antidepressants?	☐ yes	☐ no
	If yes, which one? _____		
Metabolic diseases:	Do you have diabetes?	☐ yes	☐ no
	Do you have any gastrointestinal conditions?	☐ yes	☐ no
	Do you have a thyroid condition?	☐ yes	☐ no
Nervous system diseases:	Have you ever had epilepsy/seizures, fainting or loss of consciousness?	☐ yes	☐ no
Blood diseases:	Bleeding tendency (haemophilia)?	☐ yes	☐ no
	Anaemia?	☐ yes	☐ no
Infectious diseases:	Liver inflammation/ jaundice (Hepatitis A/B)?	☐ yes	☐ no
	Tuberculosis?	☐ yes	☐ no
	Chronic respiratory diseases, cough etc.)	☐ yes	☐ no
	HIV-Infection?	☐ yes	☐ no
Other information:	Do you consume drugs or alcohol regularly?	☐ yes	☐ no
Care level:	Do you have an officially recognized care level?	☐ yes	☐ no
	If yes, which level (1 – 5) _____		
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 notice: Please inform us of any changes in your health condition before treatment. As a precaution, we would like to point out that patients who have undergone treatment with local anaesthesia for pain control should refrain from participating in road traffic (driving a car) for approximately 4 hours.

Place, Date _____ Signature _____