Practice Dr. Späth & Dr. Krauss
Dentists in Hanau

Anamnesis

Personal information

Last name ..... First name .....

Date of Birth ..... sex ☐ female ☐ male

Adress (private) .....

E-mail (private) ..... (mobile) .....

Phone (private) ..... (work) .....

Occupation/Employer .....

Family doctor (name, phone, adress) .....

Name of your health insurance .....

Please answer the following questions about your state of health as accurately as possible. This information is subject to medical privacy and data protection laws and will be handled with strict confidentiality.

Heart/cardiovascular diseases

High blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Heart valve disease	☐ Yes	☐ No
Heart valve replacement	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No
Stem cell transplant	☐ Yes	☐ No

Epilepsy	☐ Yes	☐ No
Asthma/lung diseases	☐ Yes	☐ No
Blood clotting disorders	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Drug dependency	☐ Yes	☐ No
Nerve disease	☐ Yes	☐ No
Kidney diseases	☐ Yes	☐ No
Fainting spells		
Osteoporosis	☐ Yes	☐ No
Smoker	☐ Yes	☐ No
Rheumatism/arthritis	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Other diseases:	☐ Yes	☐ No

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Infectious diseases:

HIV/AIDS	☐ Yes	☐ No
Liver disease/Hepatitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Other infectious diseases	☐ Yes	☐ No

Are you pregnant? ☐ Yes ☐ No

If yes, what month? please select ...

Allergies or intolerances:

Local anesthesia/injections	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No
Pain medication	☐ Yes	☐ No

Metals: .....

Have you had dental x-rays?

If yes, when? .....

Which medication do you take regularly or are currently taking?

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Do you take bisphosphonates?	☐ Yes	☐ No	since .....
Are you receiving chemotherapy medication?	☐ Yes	☐ No	since .....
Are you receiving radiation therapy for cancer?	☐ Yes	☐ No	since .....
Are you taking high-dosage steroids / immunosuppressants?	☐ Yes	☐ No	since .....
Have you had major surgery carried out in hospital?	☐ Yes	☐ No	Date: .....

I hereby authorise the electronic storage, processing and use of my data for input in the Recall System.

I want to be contacted for a recall ☐ no ☐ yes if yes ☐ every 6 month or ☐ every 12 months.

I agree to immediately report any and all changes arising during the entire treatment period. I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

In the case of extensive services by dentists or dental technicians for which my dentist is obliged to make payment in advance, I understand that a credit check may be carried out by a credit protection or credit reporting agency.

Location ..... Date ..... Signature .....