Dear Patient,

We very much appreciate that you have chosen our dental practice Nobis+Ganß and you entrust your health to our care. This questionnaire in English has been created for our English speaking patients to make their first visit to Nobis+Ganß even more comfortable and to avoid misunderstandings where important details are concerned. We apologize for mistakes which might have occurred, despite our greatest efforts. Do not be put off by so many questions. For your own benefit please fill in all pages of this questionnaire. Do not hesitate to ask us if you should need help. All given information are subject to medical secrecy and data protection.

Patient		**Insurance holder**	
Family name:		Family name:	
First name:		First name:	
Date of birth:		Date of birth:	
Street:		Street:	
Zip code:	City:	Zip code:	City:
Telephone (home):		Telephone (home):	
Telephone (office):		Telephone (office):	
Email address:			
Occupation:			
Employer:			

Health insurance

What kind of health insurance do you have?

Which doctor has referred you to us?	
Who recommenden our dental practice?	
How did our dental practice come to your attention?	
Friends, relatives, colleagues:	
Other:	

Health related questions

Do suffer from following diseases

High blood pressure	☐ Yes ☐ No	Convulsion disorder(e.g Epilepsy)	☐ Yes ☐ No
Heart valve defect	☐ Yes ☐ No	Asthma/Lung disease	☐ Yes ☐ No
Heart valve replacement	☐ Yes ☐ No	Blood cotting disease	☐ Yes ☐ No
Heart pacemaker	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Endocarditis/Myocarditis	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Eye disease	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Mental illness	☐ Yes ☐ No
Other infectious disease	☐ Yes ☐ No	Addiction	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Other desease:	☐ Yes ☐ No
If yes, which ones?	____________________	If yes, which one?	____________________
	____________________		____________________

Are you on a medication at present? ____

Do you smoke? ☐ Yes ☐ No

If yes, how many? ____

Have you undergone an operation in recent years? ☐ Yes ☐ No

If yes, what kind: ____

Have you had a radiotherapy? ☐ Yes ☐ No

Have you ever undergone a tumour treatment? ☐ Yes ☐ No

Have you had an organ transplanted? ☐ Yes ☐ No

Are you on a medication to depress your immune defense? ☐ Yes ☐ No

Do you take or did you take Bisphosphonate? ☐ Yes ☐ No

When was the last X-ray of your teeth taken? ____________________

Do you have an X-ray pass? ☐ Yes ☐ No

Are you pregnant or do you breastfeed? ☐ Yes ☐ No

Do you often suffer from headache or migraine? ☐ Yes ☐ No

Teeth related questions

Have you regularly been in dental treatment? ☐ Yes ☐ No

Do you have gum bleeding or did you have it in the past? ☐ Yes ☐ No

Have you undergone a periodontal treatment? ☐ Yes ☐ No

Do you notice teeth migration? ☐ Yes ☐ No

Have you had braces or dental splint? ☐ Yes ☐ No

Do you press or grind your teeth? ☐ Yes ☐ No

Do you have removable dentures? ☐ Yes ☐ No

Do you suffer from bad breath? ☐ Yes ☐ No

Who is your GP? ____

Please describe the reason for consulting our practice as accurately as possible. Is there anything about your teeth that bothers you? Which prior treatment has been made? Any advice might be helpful.

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We are interested in your particular needs:

Are you interested in dental prophylaxis? ☐ Yes ☐ No

Do you wish to be informed about advanced and better dental methods of treatment even if this will be not or partially refunded by your health insurance? ☐ Yes ☐ No

How do you wish to be reminded of your appointments in future:
By telephone:
By e-mail:____
By mail:

Important Information:

We expressly inform you that your ability to drive may be restricted after having had a local anaesthetic.

By arranging a dental appointment with us a fixed period of time is usually reserved exclusively for you. Your advantage is a minimum of waiting time and we can entirely concentrate on your treatment. We therefore kindly ask you to arrive in time for your appointment. Please cancel your appointment not later than 24 hours in advance if you should be prevented for any reason.

Nobis+Ganß are looking forward to seeing you.

Your Nobis+Ganß team.

Date: ________________________ Patient`s signature: ______________________________