CHARLES A. SMITH, DDS
& ASSOCIATES
Specialists for Aesthetic Dentistry

Registration and Medical History Questionnaire

Patient

Last name

First name

Date of birth
For patient under 18 - please list Guardian first and last name

Place of residence, German Address

Street No.

Postal code

Telephone Fax

Email

Occupation

Employer Telephone

Insurance

Main insured

Last name

First name

Date of birth
For patient under 18 - please list Guardian first and last name

Place of residence, German Address

Street No.

Postal code

Telephone Fax

Email

Occupation and Unit

Unit phone number

DEROS

DEERS Benefit Number
(if applicable)

How did you hear about us?

Why do you need dental treatment?

When was your last dental treatment?

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

	Yes	No
Would you like to have an overall treatment of your jaw?	○	○
Do your gums tend to bleed?	○	○
Do you suffer from recession of the gums?	○	○

	Yes	No
Are there any teeth loose?	○	○
Are you happy with the position, color and shape of your teeth, in short with your "smile"?	○	○
Do you trequently suffer from headache?	○	○
and/or neck pain?	○	○

Would you like to have a special consultation about:

Amalgam removal and detoxification	○	Regeneration and keeping the gums healthy	○
High-quality tooth-coloured fillings	○	(periodontal treatment)	○
Teeth Whitening (bleaching)	○	Dental implants (Branemark system)	○
High-quality dentures	○	Special methods of cosmetic dental care,	○
		e.g. ceramic veneers	○

Questions on existing diseases

A lot of diseases can effect the dental treatment. Therefore we would like you to complete this questionnaire carefully. We are happy to answer any questions that you might have. This questionnaire is added to your file. Your personal details are subject to strict medical confidentiality.

Please inform us for your own safety of any changes in your state of health that might arise so that we are able to take the changed situation into account if necessary.

Yes please provide details:	**Yes**	**No**	**Detail**
Are you currently/have you recently been receiving medical treatment?	○	○	_____
Are you taking any medication on a regular basis?	○	○	_____
Have you had reactions to injections or other medications?	○	○	_____
Do you carry a pacemaker?	○	○	_____
Have you had an HIV/AIDS test?	○	○	_____
Female patients: Are you pregnant?	○	○	_____

Do you have or have you had one of the following diseases?

Heart conditions or circulation disorder?	○	○	_____
Easy fainting?	○	○	_____
Blood disease, bleeding tendency?	○	○	_____
Hepatitis/jaundice?	○	○	_____
Allergies (e.g. hay fever, asthma, allergy pass)?	○	○	_____
Diabetes?	○	○	_____
Fits (e.g. epilepsy)?	○	○	_____
Thyroid disease?	○	○	_____
Other diseases?	○	○	_____

Who is your family doctor?

Name: _____ Telephone: _____

If during treatment a (local) anaesthetic is necessary please be aware that this can reduce your fitness to drive. Therefore you should pay special attention on the road.

Organizational notes:

This applies a scheduling system. This means that the time agreed on is reserved especially for you as high-quality work is only possible without time pressure. Normally you will have no or only short waiting periods. Medically necessary, not scheduled treatments, however, can cause delays. We apologize for any inconvenience. Please inform us immediately if you cannot keep to your appointment so that we can reschedule this time. Otherwise we are entitled to charge for the idle time (§§304,614 BGB). If you make an appointment at short notice due to an emergency (e.g. tooth pain) you will have to take waiting periods into account.

We would like to ask you to confirm your agreement to this procedure by signing underneath.

_____ _____

Place, date signature of the patient or parent