DR. GOPPERT & DR. WALTER
ZAHNÄRZTE MVZ PartG

AESTHETIC DENTISTRY
IMPLANTOLOGY
PERIODONTOLOGY

Questionnaire | History

Welcome to our practice!

In order to guarantee a complication-free course of treatment and correct management of your documents, we would like to request some personal information. Of course, all statements are subject to confidentiality and data privacy. If you are not clear about an answer, we will gladly clarify that in a personal conversation. Please do not forget to also answer the questions on the reverse side.

The practice team would like to thank you for your conscientious cooperation.

PERSONAL DATA

Name | First name | Date of birth | Place of birth

Co-insured with:

Name | First name | Date of birth

Street, House No. | Postal code, location

Telephone (private) | Telephone (business*)

Mobile phone | Fax

E-Mail (please indicate, if available)

Occupation* | Employer, job location*

Family doctor

INFORMATION ON INSURANCE COVERAGE

Health insurance company

If you are co-insured: Does the main person insured have the same address? ☐ Yes ☐ No

If no:
Street, House No. | Postal code, location

Are you additionally insured? ☐ Yes ☐ No

Are you eligible for benefit? ☐ Yes ☐ No

MISCELLANEOUS

How did you become aware of us?

☐ Friends / acquaintances _____

☐ Internet _____

☐ Other: _____

Who referred / recommended you?

*The information marked with an asterisk (*) is voluntary.

Please also note the reverse side ▸

YOUR GENERAL STATE OF HEALTH

Are you currently taking medication? If so, which?		☐ Yes	☐ No
Do you regularly take special medication to inhibit blood clotting (e.g. Aspirin®, ASS 100, Marcumar®, Xarelto®, Pradaxa®)? If so, which?		☐ Yes	☐ No
Do you take bisphosphonates (medication against osteoporosis)?		☐ Yes	☐ No
Do you have heart problems or a heart disease (e.g. heart attack, heart failure, pacemaker)? If so, what do you suffer from?		☐ Yes	☐ No
Do you have a Herzpass (heart disease ID)?		☐ Yes	☐ No
Have you had a stroke?		☐ Yes	☐ No
Do you have a liver disease (e.g. hepatitis A, B or C, jaundice)? If so, which?		☐ Yes	☐ No
Have you been tested for HIV ? If so, in which year was the test conducted? With which result?		☐ Yes ☐ Positive	☐ No ☐ Negative
Do you have a form of Creutzfeldt-Jakob disease?		☐ Yes ☐ The new variant	☐ No
Do you have a gastrointestinal disease? If so, which?		☐ Yes	☐ No
Do you suffer from a blood disease?	Anaemia	☐ Yes	☐ No
	Tendency to bleed	☐ Yes	☐ No
Do you have metabolic disorders?	Diabetes	☐ Yes	☐ No
	Thyroid disease	☐ Yes	☐ No
	Kidney disease	☐ Yes	☐ No
Do you have circulatory disorders?	Fainting spells	☐ Yes	☐ No
	Low / high blood pressure	☐ Yes	☐ No
Do you suffer from:	Rheumatism	☐ Yes	☐ No
	Asthma / chronic bronchitis	☐ Yes	☐ No
	Epileptic seizures	☐ Yes	☐ No
	Tuberculosis	☐ Yes	☐ No
	Migraine	☐ Yes	☐ No
	Headaches	☐ Yes	☐ No
	Earaches	☐ Yes	☐ No
	Neck pains	☐ Yes	☐ No
	Cranial injury	☐ Yes	☐ No
	Pain in the temporomandibular joint	☐ Yes	☐ No
	Popping in the temporomandibular joint	☐ Yes	☐ No
	Maxillary sinusitis	☐ Yes	☐ No
Do you have an allergy against:	Medications (e.g. Aspirin®, penicillin)? If so, which?	☐ Yes	☐ No
	Latex	☐ Yes	☐ No
Do you have an allergy ID?		☐ Yes	☐ No
Do gum diseases occur frequently in your family?		☐ Yes	☐ No
Do you smoke?		☐ Yes	☐ No
For women: Are you pregnant?		☐ Yes	☐ No
When and which part of your body was most recently X-rayed?			
Other information relevant for your treatment:			

Responsiveness in road traffic can be restricted after anaesthesia. Firmly booked appointments which are not kept must be cancelled 24 hours in advance, because otherwise a cancellation fee may possible be charged. With my signature I confirm the accuracy of my statements.

We ask you to please tell us if changes in your health status or your insurance status arise during treatment.

Stuttgart, [date] Signature

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You are particularly important to us!

WHAT SHOULD WE PARTICULARLY TAKE INTO ACCOUNT DURING YOUR TREATMENT?

Are you afraid of dental procedures? ☐ Yes ☐ No

Do you have a strong urge to gag? ☐ Yes ☐ No

Up to now, what have you missed during a visit to the dentist?

CONSULTATION REQUEST

I would like special consultation with regard to:

- ☐ Professional teeth cleaning
- ☐ Options for treatment of periodontitis
- ☐ Tooth whitening (bleaching)
- ☐ Dental aesthetics / "My Smile"
- ☐ Tooth-coloured plastic fillings
- ☐ Biocompatible all-ceramics
- ☐ Amalgam sanitation
- ☐ Implants / implant restoration
- ☐ Other:

MY HEALTH IS IMPORTANT TO ME!

☐ I would like to prevent further damage to teeth and periodontium and therefore would like to participate in the dental practice's automatic recall system. As a result, I will be reminded of the follow-up and dental cleaning appointments in writing or telephonically at regular intervals.

Stuttgart, [date] Signature

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