LORENZ
ENDODONTIE & TRAUMATOLOGIE

Dr. med. dent. Stefan Lorenz
Tal 14
80331 München
Tel.: 089 / 23 23 27 66
Fax: 089 / 23 23 27 67
info@endodontie-marienplatz.de
www.endodontie-marienplatz.de

PATIENT DATA SHEET

– please print all information –

Family Name, First Name (Patient)

Date of Birth

Street Address

Zip, City, Country

Home Phone/Cell Phone

Work Phone

E-Mail

Profession

Insurance Company Name

- ☐ Legally insured
- ☐ Private insured - no basic tariff
- ☐ Private insured - basic tariff
- ☐ Beihilfe
- ☐ Additional insurance

Referring Physician - Name, Address, Phone

Family Doctor - Name, Address, Phone

If insured person is differing from patient mentioned above please fill in:

Family Name, First Name (insured person)

Date of Birth

Street Address

Zip, City, Country

Consent of Treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a minor is required:

Date

Parent/Legal Guardian Signature

Please answer the following questions regarding your state of health as exactly as possible:

Cardiovascular Diseases: ☐ Yes ☐ No

If yes, what ____________________

Allergies / Intolerances: ☐ Yes ☐ No

If yes, what ____________________

Infectious Diseases:

AIDS ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
other: ____________________

Further Diseases:

Coagulation Diseases ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Nephropathy ☐ Yes ☐ No
other: ____________________

General Data:

Regular Medication ☐ Yes ☐ No If yes, name? ____________________
Smoker ☐ Yes ☐ No If yes, how much? ____________________
Drug Addiction ☐ Yes ☐ No If yes, what? ____________________

X-Rays taken before
in the mouth and maxillofacial region ☐ Yes ☐ No If yes, date? ____________________

Gravidity/Pregnancy ☐ Yes ☐ No If yes, what month: ____________________

How did you get informed about our dentist's practice? ____________________

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Important Information:

All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. I agree to those data being saved and processed electronically. I engage myself to inform you immediately about all changes occuring during the period of treatment. I engage myself to keep agreed appointments or to chancel them at least 1 day in advance, otherwise occuring costs can be invoiced. I certify with my signature that I have read and understand all above printed information.

____
Date

____
Patient Signature and Parent/Legal Guardian Signature