

# Zahnarztpraxis Dr. Yasmin Awwad Dr. Katja Hasselberg

First name \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Last name \_\_\_\_\_ Telephone / Mobile \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Profession / Employer \_\_\_\_\_  
 Street / Nr. \_\_\_\_\_ Care level \_\_\_\_\_  
 Residence \_\_\_\_\_ Degree of disability \_\_\_\_\_  
 Postal code \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Allowance  yes  no

Private Insurance?  yes  no standard / basic tariff  yes  no

**How did you find the practice?**

Family / Friends (Name)       Homepage       Internet       Rating portal

Do you have a supplementary dental insurance?  yes  no

Were you in medical treatment within the last year?  yes  no

If yes, due to which disease? \_\_\_\_\_

Do you take any medication?  yes  no

If yes, which? \_\_\_\_\_

Are you allergic to medication or materials?  yes  no

If yes, which? \_\_\_\_\_

Do you have an allergy pass?  yes  no

Are you addicted to alcohol?  yes  no      Are you addicted to drugs?  yes  no

Do you bleed long after injuries or tooth extraction?  yes  no

Do you own a heartpass?  yes  no      Do you wear a pacemaker?  yes  no

Do you have an artificial heart valve?  yes  no

Did you suffer from endocarditis and need endocarditis prophylaxis?  yes  no

**Do or did you have any of the following diseases?**

Cardiovascular diseases (e.g. high / low blood pressure, atherosclerosis)?  yes  no

Blood diseases (e.g. clotting disorder, hemophilia)?  yes  no

Diseases of the paranasal sinuses (e.g. sinusitis)?  yes  no

Lung diseases Asthma?  yes  no      Tuberculosis (TB)?  yes  no

Liver diseases (Hepatitis)?  yes  no

Kidney diseases?  yes  no

Rheumatism, rheumatoid arthritis, osteoporosis?  yes  no

Diabetes mellitus (Type I or II)?  yes  no

Thyroid disease?  yes  no

Glaucoma, narrow-angle glaucoma, cataract?  yes  no

Seizures, convulsions, epilepsy, fainting, syncopes  yes  no

Cancer, tumor?  yes  no      radiation in the head / neck area  yes  no

HIV positive  yes  no

Are you happy with your tooth colour?  yes  no

Do you suffer from bad breath?  yes  no

Do you want to participate in our reminder service?  yes  no

If your health condition changes during the treatment, please inform us immediately.

Please note, that we can charge a cancellation fee according to § 615 BGB for skipped appointments. If you want to change an appointment, please tell us 24 hours in advance. By signing this form I confirm the correctness of my given data.

\_\_\_\_\_  
Berlin, date, signature