PRAXIS DR. GEBEFÜGI

Dear Patient,

as a part of your dental treatment it is important, that we have as much information as possible, about your current health situation. We would therefore ask you, to read and answer the questions below and if necessary add any valuable information to your answers.

Patient Surname, First Name: ______ Job: ______

Place of birth: ______ Date of birth: ______

Policyholder Surname, First Name: ______ Date of birth: ______

Address Street/No.: ______ Post Code/Place ______

Phone: ______ Cell-Phone: ______ E-Mail: ______

Health Insur. Company ______ Rate type: ______

I received and read the Privacy policy: ______ ______

Date Signature

Are you pregnant or may believe you are? ○ No ○ Yes (which month?: ______)

Are you currently suffering from

Metabolic diseases:

diabetes ○ Yes ○ No

gastrointestinal diseases ○ Yes ○ No

thyroid diseases ○ Yes ○ No

hormone malfunctions ○ Yes ○ No

other ______

Nervous system diseases:

epileptic attacks / seizures ○ Yes ○ No

neurolical / nerval disorders ○ Yes ○ No

paralysis ○ Yes ○ No

other ______

Blood disorders:

tendency to bleed (haemophilia) ○ Yes ○ No

anaemia ○ Yes ○ No

Allergies:

eczema ○ Yes ○ No

asthma ○ Yes ○ No

penicillin intolerance ○ Yes ○ No

allergy ID ○ Yes ○ No

hypersensitivity to ______

Anticoagulant medication

permanent or in the last few days (e.g.)

○ Aspirin® ○ ASS® ○ Marcumar® ○ Ticlopidin®

○ Clopidogrel® ○ Plavix® ○ Bisphosphonates

or ______

Infectious diseases

hepatitis / jaundice ○ Yes ○ No

tuberculosis ○ Yes ○ No

aids ○ Yes ○ No

other ______

Pain in the head area:

headache ○ Yes ○ No

earache ○ Yes ○ No

a cracking motion in the ears while chewing/yawning ○ Yes ○ No

tinnitus ○ Yes ○ No

dizziness ○ Yes ○ No

glaucoma/ cataract ○ Yes ○ No

restricted movement while opening the mouth – Lockjaw ○ Yes ○ No

other ______

Skeletal or muscular pain

back pain ○ Yes ○ No

pain in the cervical spine ○ Yes ○ No

spinal disc damage or slipped discs ○ Yes ○ No

rheumatic pain ○ Yes ○ No

fibromyalgia ○ Yes ○ No

operations: ○ Yes ○ No

other ______

Regular medication

e.g. blood pressure/heart medication ○ Yes ○ No

pain killers ○ Yes ○ No

contraceptive medication - „Birth control pill“ ○ Yes ○ No

psychotropic drugs ○ Yes ○ No

diabetic medication ○ Yes ○ No

which ______

Heart/circulation:

○ heart defects ○ angina pectoris ○ heart attack

○ myocarditis ○ heart valve disease ○ artificial valve

○ pacemaker ○ high or ○ low blood pressure

○ stroke ○ dysrhythmia

other ______

Information about dental local anesthetics

We consider the use of dental local anesthetics to provide and also eliminate pain in the teeth, mouth or facial region. We preferably recommend dental local anesthetics for treatments such as root canal treatments, operations in or around the mouth region, deep fillings or extractions of teeth in order to prevent pain during those treatments.

In order to numb the affected area in the upper jaw, we inject the local anesthetics close to the nerve fibers of the teeth. For the lower jaw, the anesthetics are placed in a main branch of the "nervus trigeminus" which causes a numbing feeling in either the whole left or right side of the upper jaw.

We cannot always avoid side effects like allergic reactions or bruising which could be caused by the use of those dental local anesthetics.

In rare cases, the following complicatons can occur:

Hematoma (bruising)

Damaging small blood vessels can cause bleeding in the surrounding tissue. The injection in one of the Jaw muscles can cause bleeding which can result in pain, restricted movement when opening the mouth or in very rare cases infections. Please inform us immediately if you experience any of those side effects, so that we can take suitable actions by treating them as soon as possible.

Nerve damages

In very rare cases, anesthetizing in the Mouth region can cause irritations on the nerve fibers. This could lead to temporary or permanent sensational disturbances also to numb feelings on parts of the tongue, lower jaw or lip. Please inform us immediately if the numb feeling is at least lasting longer than 12 h.

Roadworthiness

Local anesthetics and the following dental treatment can cause impaired responsiveness and an inability to concentrate. Therefore you should avoid driving after some treatments.

Self-caused injuries

Please do not eat until the effect of the local anaesthetic has fully worn off. The lack of feeling in this region can lead to bite wounds, burns and cold burns.

Our Recall-System

Would you like us to remind you of your annual visit? ◯ **Yes** ◯ **No**

I am ready to participate in the recall service by phone, letter or e-mail. I agree with the storage of my personal data through the practice. I have been enlightened that I can revoke this consent at any time by writing a letter or e-mail to the practice. (Article 7 (3) DSGVO). I am also aware of the fact that my revocation of consent, which is possible at any time, does not affect the legal processing carried out on the basis of consent until the revocation. (Article 7 (3) sentence 2 DSGVO). If you have any further questions, please do not hesitate to contact me or my staff. We are happy to answer.

Please let us know how you wish to be treaded

◯ **Cost-optimized therapy**

I want to receive high quality treatments but they should be as cost efficient as possible. I am aware of the fact, that this kind of treatment system may include methods that are not as modern as those, who are higher in cost. I also wish to be informed about every "method of treatment" – paper that is written, so I can coordinate the costs with my Insurance. I will point specific suggestions on my treatment out to you separately.

◯ **Quality-optimized therapy:**

I want the most and high graded therapy, including all relevant possibilities of modern methods that are available in dentistry. Not only do I want to be informed about long lasting, comfortable treatments and materials of the highest quality, I also want aesthetics and functional aspects to be considered for my treatments. I will point out the need for a "treatment and cost"- paper for negotiations with my insurance to you separately.

◯ **Teeth Whitening / Bleaching methods**

I want to be informed about teeth whitening or bleaching methods provided by your practice.

I confirm that all the information I provided to you are correct. ______________ ______________

Date Signature

I was recommended to you by: ______________________________

Last X-ray examination: ______________________________

Please cancel agreed appointments at least 24 hours in advance. We reserve the right, in the case of unexcused non-appearance, to charge a cancellation fee, depending on the planned duration of up to 300 EUR.

Note for private patients: Based on the contract and insurance conditions of your private health insurance company, the treatment may not be fully reimbursed.