Dr. Kevin Dauter | Dr. Friederike Dauter



Dear patients, we are pleased that you entrust us with your health!

It is our aim to provide you with the best possible individual treatment. Therefore, we would like to ask you to take a few minutes to read this questionnaire carefully and to fill it out as accurately as possible. We will talk about the most important questions and answers in detail with you in a moment. The information you provide with this questionnaire will only be used to optimize your treatment and will be kept confidential and not disclosed to any third party without your permission.

# 1. *Personal information*

Surname, Given names ______ Date of birth ______ Place of birth ______ ☐ m ☐ f

Current address ______

Postal/Zip code ______ City/Country ______

Phone/Mobile ______ E-mail ______

Profession ______ Employer ______

**I ...**

☐ am covered by the statutory health insurance

☐ have an additional insurance
Which insurance company?
______
______

☐ have a private health insurance
Which insurance company?
______
______

☐ Eligible for aid ☐ Base rate insurance

Name of your family doctor / medical specialist? ______

Name of your family dentist? ______

## WERE YOU REFERRED TO US BY A COLLEAGUE? IF YES, BY WHOM?

______

## HOW DID YOU FIND OUT ABOUT US?

☐ Google ☐ Jameda ☐ Website ☐ Recommendation from ______ ☐ Other ______



Markgrafenstraße 2
04109 Leipzig

Tel. 0341 - 911 58 34
Fax 0341 - 912 04 76

praxis@m2-merkurhaus.de
www.m2-merkurhaus.de

# 2. General health questions

### DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING CARDIO/CIRCULATORY DISEASES?

| | | |
|---|---|---|
| Do you have blood pressure disorders? | ☐ Yes | ☐ No |
| Do you have a tendency to faint? | ☐ Yes | ☐ No |
| Angina pectoris? | ☐ Yes | ☐ No |
| Heart attack? | ☐ Yes | ☐ No |
| Arrhythmia? | ☐ Yes | ☐ No |
| Cardiac pacemaker/defibrillator? | ☐ Yes | ☐ No |
| Inflammation of the valves / muscle? | ☐ Yes | ☐ No |
| Do you have an artificial heart valve? | ☐ Yes | ☐ No |
| Stent / by-pass? | ☐ Yes | ☐ No |

### DO YOU HAVE ANY OF THE FOLLOWING DISEASES?

| | | |
|---|---|---|
| Diabetes? | ☐ Yes | ☐ No |
| Thyroid disorders? | ☐ Yes | ☐ No |
| Gastrointestinal diseases? | ☐ Yes | ☐ No |
| Liver diseases? | ☐ Yes | ☐ No |
| Rheumatism? | ☐ Yes | ☐ No |
| Kidney diseases / dialysis? | ☐ Yes | ☐ No |
| Osteoporosis? | ☐ Yes | ☐ No |

### DO YOU HAVE THE FOLLOWING BLOOD OR VASCULAR DISEASES?

| | | |
|---|---|---|
| Thrombosis? | ☐ Yes | ☐ No |
| State after a stroke? | ☐ Yes | ☐ No |
| Are you taking anticoagulant (blood-thinning) medications? | ☐ Yes | ☐ No |
| Coagulation disorders? | ☐ Yes | ☐ No |
| Bleeding tendency / hemophilia? | ☐ Yes | ☐ No |
| Lack of blood / anemia? | ☐ Yes | ☐ No |

### DO YOU HAVE ANY OF THE FOLLOWING RESPIRATORY OR PULMONARY DISEASES?

| | | |
|---|---|---|
| Chronic bronchitis? | ☐ Yes | ☐ No |
| Lung diseases /Asthma? | ☐ Yes | ☐ No |
| Do you smoke? | ☐ Yes | ☐ No |

### DO YOU HAVE ANY OF THE FOLLOWING DISEASES?

| | | |
|---|---|---|
| Metastases / daughter tumors? | ☐ Yes | ☐ No |
| Muscle diseases? | ☐ Yes | ☐ No |
| Hepatitis / jaundice? | ☐ Yes | ☐ No |
| Stomach ulcer? | ☐ Yes | ☐ No |
| Infectious diseases? | ☐ Yes | ☐ No |
| Immunodeficiency / AIDS? | ☐ Yes | ☐ No |
| Seizure disorder / epilepsy? | ☐ Yes | ☐ No |
| Depressions? | ☐ Yes | ☐ No |
| Anxiety? | ☐ Yes | ☐ No |
| Addictive diseases? | ☐ Yes | ☐ No |
| Eye diseases / glaucoma? | ☐ Yes | ☐ No |

# 3. Other

**Any malignant diseases?** ☐ Yes ☐ No

If yes, please specify

___

**For female patients**

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

**Are you taking any medication on a regular basis?**
**If yes, which medication?**

___

___

___

___

**Do you have any hypersensitivity or allergy?** ☐ Yes ☐ No
**If yes, please specify**

___

___

___

___

**Are you intolerant to certain medications?** ☐ Yes ☐ No

If yes, which ones?

___

# *4. Legal advice / data protection*

We kindly ask you to notify us **at least 24 hours in advance** of any appointments you are unable to keep, otherwise you may be charged for any costs incurred due to your absence (45 minutes or more).

**Information on fitness to drive after (dental) treatment under local anesthesia**
Please note that your ability to drive a car may be impaired for up to 24 hours after (dental)-treatment under local anesthesia. This can be caused by the treatment itself as well as by the influence of injections or other medications. On your request, we will therefore be happy to call a cab to take you home safely.

**Acceptance of X-ray declaration**
I hereby give my consent for necessary X-ray examinations to be carried out on me as part of my (dental)-treatment. I hereby consent to the practice M2 | Praxis im Merkurhaus obtaining findings and treatment data (e.g. existing X-rays) from other service providers (e.g. orthodontist / general practitioner / family dentist / laboratory) and sharing medical records obtained in the practice with treating medical specialists.

**Data protection information and declaration of consent to data processing according to EU-GDPR**
At this point, we would like to inform you that personal data is collected and stored in the course of (dental) medical treatment in our practice. The collection and storage of the data is necessary for the treatment according to Art. 6 para. 1 b) EU-GDPR. By signing this page, you expressly consent to the collection and storage of personal data necessary for your treatment. You have the right to revoke this consent at any time, however, a revocation is only effective for the future, since according to legal regulations a documentation of your treatment data is mandatory. After revocation of this declaration of consent, however, further treatment is no longer possible.

Further information on data protection, which rights you have with regard to data protection or information on the purpose for which our practice collects, stores or passes on data can be obtained at any time on request at our reception.

I have filled out this questionnaire to the best of my knowledge and confirm with my signature that the provided information are complete and correct. Furthermore, I will inform you if there are any changes in the provided information.

Place, Date

Patient's signature


Markgrafenstraße 2
04109 Leipzig
Tel. 0341 - 911 58 34
Fax 0341 - 912 04 76
praxis@m2-merkurhaus.de
www.m2-merkurhaus.de