Prof. Rupprecht
& Kollegen
Mund-Kiefer-Gesichtschirurgie
Plastische Operationen

Prof. Dr. Dr. S. Rupprecht
Hugenottenplatz 1
91054 Erlangen
fon +49(0) 9131 92006-0
fax +49(0) 9131 92006-20
info@mkg-erlangen.de
www.mkg-erlangen.de

Dear patient

**Welcome to our clinic. Please fill out the following medical history completely and enter it afterwards at the reception.**

Thank you!

Surname: _____ First name: _____

Date of birth: _____ Guardians / guardian _____

Address: _____

Postcode/City: _____ E-Mail: _____

Phone: _____ Cell Phone: _____

**Dentist**: _____

**Orthodontists**: _____

**General practitioner:** _____

Transfer/recommendation by: _____

Insured:

- ☐ **Health insurance** _____
- ☐ **Stationary insurance:** _____
- ☐ **Implant insurance:** _____
- ☐ **Privat** _____
- ☐ **Allowance** _____

Our dental team strives to coordinate the scheduling after consultation with our patients in order to establish short waiting times for you. This service can only be used perfectly when deadlines are kept or canceled in time (24h in advance). We use the Doctolib calendar software for all of our patients to manage appointments consistently.Doctolib processes all data in accordance with all applicable data protection regulations and applies the highest security standards. To make an appointment, the following data is entered into the Doctolib calendar: last name, first name, date of birth, address, telephone number, email address, family doctor, health insurance status, referring doctor, reason for visit and appointment history.

I agree that treatment data and findings (X-rays, histological findings, etc.) concerning me may be transmitted to my treating physicians / dentists (by mail, by email, by telephone, etc.).
This declaration may be revoked in whole or in part by you at any time.

I certify with my signature that I fully understood the text and in the medical history (anamnesis) all known to me suffering and discomfort have called.
Erlangen, _____ _____
Signature of patient

_____
Signature of guardian/s

**Please turn the paige!!**

Please answer the following questions about your health condition as accurately as possible

| Health | Yes | No | Additional information |
|---|---|---|---|
| **Cardiovascular disease:** | | | |
| High blood pressure (hypertension ) | | | |
| High blood pressure (hypertension ) | | | |
| Bleeding disorders | | | |
| Valvular heart disease / defect | | | |
| Pacemaker | | | |
| Heart Surgery (which one?) | | | |
| **Infectious diseases:** | | | |
| HIV | | | |
| Hepatitis (which one?) | | | |
| Tuberculosis | | | |
| other: | | | |
| **Allergies / intolerances: (Please present a list of allergy!)** | | | |
| Local anesthetics | | | |
| Painkillers | | | |
| Antibiotics | | | |
| others: | | | |
| **Weitere Erkrankungen:** | | | |
| respiratory diseases | | | |
| Thyroid dysfunction | | | |
| Rheumatism | | | |
| Epilepsy | | | |
| Diabetes | | | |
| Renal dysfunction | | | |
| Cancer | | | |
| Chemotherapy/Radiation | | | |
| others | | | |
| **General information:** | | | |
| Smoking | | | |
| Gag stimulus | | | |
| Anxiety patient | | | |
| Do you consume more alcohol? | | | |
| Do you consume more drugs | | | |
| Pregnancy (which month?) | | | |
| X-ray of the jaw area (when?) | | | |
| Declaration of consent X-ray (Kids under age of 18) | | | |
| Declaration of consent photo | | | |
| Regular medication, which one?**(Please resent a list of medications!)** | | | |