zahnärzte kirchplatz 6

Dr. Stefan Sonner | Dr. Agnes Pach
Joint practice for Dentistry & Oral Surgery
Kirchplatz 6, 82049 Pullach
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· Cosmetic dentistry
· Impression-free restorations
· Microscopic endodontics
· Oral surgery (Specialist dentist)
· Implantology, Pediatric dentistry

Welcome to our dental practice
Before we take time to talk to you in person about your individual dental wishes and requirements, we need your personal details as well as information about your general state of health. This is important for suitable and risk-free treatment. All the information given is subject to medical confidentiality.

Dr. Stefan Sonner
Dr. Agnes Pach

Information about our organisation – Appointment-based practice
Where necessary, we will reserve a series of appointments for you. This saves long waiting times and means we are available exclusively for you at the agreed time. Quality work is only possible without being rushed and under time pressure. Please bear in mind that missed appointments which are not cancelled 24 hours beforehand will be invoiced in accordance with the German scale of fees for dentists (Gebührenordnung für Zahnärzte GOZ).

Name (Mr / Mrs / Child)

First name

Street, house number

Postal code, city

Date of birth

Telephone, private

Mobile phone no.

Telephone, business

Email

Profession

Employer

Our dental practice was recommended to you by:

Data protection information
I have read and understood the data protection declaration of the dental surgery “Dr. Stefan Sonner and Dr. Agnes Pach” according to the General European Data Protection Regulation GDPR of 25 / 5 / 2018 and accept its terms and conditions.

Name / Date / Signaturet

Name of your health insurance

- ☐ Privately insured
- ☐ Entitled to aid (federal, regional, municipal or similar)
- ☐ Not insured
- ☐ Compulsory member
- ☐ Voluntary member
- ☐ Pensioner
- ☐ As family member / relative included in the patient’s insurance

Name of the insured member / Date of birth

Do you have an additive private insurance? ☐ Yes ☐ No

Recall
Would you like to be informed, especially, about our intensive prophylaxis program? ☐ Yes ☐ No

Would you like to be included in our recall card index? ☐ Yes ☐ No

For statutory health insurance patients
Would you like us to inform you if more modern and better dental treatments are possible, even if these services would not be paid for by the statutory health insurances? ☐ Yes ☐ No

 Admission form

Medical treatment
Are you currently receiving medical treatment? ☐ Yes ☐ No
If yes, for what disorder?

Family doctor / Specialist
Name, address, telephone

Medications
What medications do you regularly take?

Allergies
To which materials or medications are you suspected of being hypersensitive?

Do you have an allergy pass? ☐ Yes ☐ No

Heart diseases
Cardiac insufficiency (weakness) ☐ Yes ☐ No
Irregular heartbeat? ☐ Yes ☐ No
Angina pectoris? ☐ Yes ☐ No
Status following a heart attack? ☐ Yes ☐ No
Pacemaker? ☐ Yes ☐ No
Heart defect, valve replacement? ☐ Yes ☐ No
Endocarditis? ☐ Yes ☐ No
Other?

Vascular diseases
High blood pressure? ☐ Yes ☐ No
Low blood pressure? ☐ Yes ☐ No
Other?

Vegetative disorders
Fainting spells? ☐ Yes ☐ No
Do you take stimulants or sedatives? ☐ Yes ☐ No
Other?

Diseases of other organs
Diabetes? ☐ Yes ☐ No
Pulmonary diseases/Asthma? ☐ Yes ☐ No
Thyroid disorders? ☐ Yes ☐ No
Gastrointestinal disorders? ☐ Yes ☐ No
Kidney disorders? ☐ Yes ☐ No
Osteoporosis? ☐ Yes ☐ No
Do you take bisphosphonates? ☐ Yes ☐ No
Other?

Disorder of the nervous system
Epileptic seizures? ☐ Yes ☐ No
Convulsions? ☐ Yes ☐ No
Other?

Blood disorders
Increased bleeding tendency (haemophilia)? ☐ Yes ☐ No
Anaemia? ☐ Yes ☐ No
Do you take anticoagulant medications (Marcumar / ASS)? ☐ Yes ☐ No
Other?

Infectious diseases
Liver inflammation / jaundice (hepatitis A / B / C)? ☐ Yes ☐ No
Tuberculosis? ☐ Yes ☐ No
Chronic respiratory diseases, coughs, etc.? ☐ Yes ☐ No
Have you had an aids test? ☐ Yes ☐ No
If yes, what was the result? ☐ pos. ☐ neg.
Other?

Further details
Do you smoke? If yes, how many? ______ Day
Are you dependent on drugs or alcohol? ☐ Yes ☐ No

X-rays
Has an X-ray been taken of your head / jaw / dental area within the last 12 months? ☐ Yes ☐ No
If yes, where?

(our modern digital X-ray machines minimise the radiation dose)

Are you pregnant?
If yes, in which month?

1	4	7
2	5	8
3	6	9

Remarks

Many thanks for your cooperation!
Please inform us immediately of any changes in your personal details

Name / Date / Signaturet