Private Universität Witten/Herdecke gGmbH · University Dental Clinic
Alfred-Herrhausen-Str. 45 · D 58455 Witten

Patient questionnaire

Dear patient,
welcome to our university dental clinic. Please complete this questionnaire in order to ensure best possible dental treatment and care. All information will be treated as confidential!

Patient:
☐ male
☐ female

Last name, first name _____ date of birth _____

Street, number _____

Postal code, city _____ phone _____

Insuree:
☐ spouse
☐ father/mother

Last name, first name _____ date of birth _____

Street, number, postal code, city _____

Occupation: (Patient) _____

Employer: (Patient) _____
Name/ address/ phone

Health fund: _____ Insurance number _____
Name

Type of health insurance:

☐ private insurance
- ☐ allowance
- ☐ base rate
- ☐ full insurance

☐ statutory insurance
- ☐ compulsory insurance
- ☐ voluntary insurance
- ☐ supplementary private insurance

☐ Co-payment exemption _____
- ☐ allowance
- ☐ supplementary insurance
- ☐ cost reimbursement

Family doctor: _____

Dentist: _____

Legal guardian (if applicable): _____

Do any of these health problems or risk factors apply to you?	Yes	No	Don't know
1. Cardiovascular disease? (specifically: hypertension, valvular heart defect, arrhythmia). If so, which?	☐	☐	☐
2. Do you have a cardiac pacemaker/ defibrillation implant?	☐	☐	☐
3. Asthma, chronic obstructive lung disease or other respiratory ailment?	☐	☐	☐
4. Hemopathy or hemorrhage? Do you take coagulation inhibitors (for example: ASS, Marcumar)?	☐	☐	☐
5. Diabetes mellitus?	☐	☐	☐
Insulin required?	☐	☐	☐
6. Glaucoma?	☐	☐	☐

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		Yes	No	Don't know
7.	Infectious diseases? (for example jaundice/hepatitis, tuberculosis/Tbc, HIV/AIDS) If so, which?	☐	☐	☐
8.	Allergies/ hypersensitivity reactions? If so, which?	☐	☐	☐
9.	Autoimmune diseases (for example rheumatism)? If so, which?	☐	☐	☐
10.	Thyroid malfunctions? If so, which?	☐	☐	☐
11.	Organic diseases (for example liver or kidney)? If so, which?	☐	☐	☐
12.	Nerve diseases (for example epilepsy)? If so, which?	☐	☐	☐
13.	Consumption habits (smoking / alcohol)? If so, which, how much?	☐	☐	☐
14.	Are or were you addicted to alcohol?	☐	☐	☐
15.	Do you take drugs / intoxicants? If so, which?	☐	☐	☐
16.	Any other health problems not mentioned so far? If so, which?	☐	☐	☐
17.	**Females:** Are you pregnant? Which week?	☐	☐	☐

Medication/ Dosage:

_____

_____

Do/did you experience complications in dental treatment?

_____

_____

For patients with mental, physical or psychological handicaps:

Diagnosis: _____

Is the patient able to cooperate with treatment? ☐ yes ☐ no ☐ to a limited extent

Please keep us informed of any changes in your address, state of health, medication, and – in case of female patients – of possible pregnancy!
Please be advised that anesthesia may impair your ability to drive a car and/or operate machines for up to 24 hours.

Evaluation of treatment outcomes and research projects require analysis of data recorded in dental treatment, in the interest of comprehensive patient care. This is why we ask for your consent as follows:
I herewith consent to data recorded in the course of regular dental treatment being analysed in anonymized form that does not permit identification of individual patients. **☐ I herewith consent to data collection.**

I consent to being invited for check-ups and prophylaxis appointments: ☐ yes ☐ no

_____ _____

Place, date signature: patient or legal representative