Dear patient,

Thank you for your interest in an orthodontic treatment in our practice. We would like to ask you to complete the following pages concerning the medical history of yourself and return the form as soon as possible.

Please be advised of the following information for patients (aged 18 and over) that are covered by a statutory health insurance:

Your consultation costs 35,- Euros.

The statutory health insurance covers the costs in the case of rare orthodontic surgery. If this case applies to you, we will be able to reimburse the above consultation costs after your statutory health insurance has successfully approved your orthodontic treatment plan.

Our postal address is:

Kieferorthopädische Fachpraxis
Dr. Anja Gutmark
Dr. Ruben Lipphardt
Kurfürstenstr. 14
60486 Frankfurt

via email: praxis@drgutmark.de

via fax: 069- 900 198

Upon return of the completed document, we will contact you in order to arrange a suitable appointment.

Referral Information:

Who recommended us?

_____

Preferred Contact Details:

□ by phone, your contact number:

_____

or

□ by email, your email address:

_____

Thank you!

Sincerely,

Praxis Dr.A.Gutmark

Patient Information:

Last Name: _____

First Name: _____ □ **Male** □ **Female**

Date of Birth: _____

Place of Birth: _____

Home Address:

Street Name and House Number: _____

Postal Code and City: _____

Phone: _____

Mobile / Cell: _____

Email: _____

Please state your current dentist:

Name / Place: _____

Please state your health insurance company:

Name: _____

Medical History Details (all personal details will be treated discreetly - please also update us of any recent medical changes as soon as possible)

Did or do you have any of the following sicknesses?

☐ Asthma
☐ Diabetes
☐ Rheuma
☐ Osteoporosis
☐ Blood Disease
☐ Blood Coagulation Disorder
☐ AIDS or HIV-Infection
☐ Tuberculosis
☐ Liver Disease
☐ Hepatitis Type A/B/C
☐ Epilepsy (Seizure Disorder)
☐ Thyroid Disorder, please specify: _____
Since when? _____

□ **All of above sicknesses: NO**

Allergies:

☐ Allergies, please specify: _____
☐ Allergic reactions to prescription drugs, medicine etc., please specify:

□ **All of above allergies: NO**

Other conditions:

☐ Heart Attack / Stroke
☐ Marcumar
☐ Paralysis
☐ High Blood Pressure
☐ Low Blood Pressure

□ **All of above conditions: NO**

Do you have a heart pace maker?

□ Yes
□ No

Do you suffer from a heart problem or had heart surgery?

□ Yes
□ No

Do you take medication on a regular basis?

□ Yes, please specify: _____
□ No

Further details / other sicknesses: _____

Has your head been x-rayed before?

□ Yes, when? _____

In the following practice (please indicate in order for us to request any relevant x-rays):

_____

□ No, there haven't been any x-rays so far.

Personal Details:

Do you use insoles in your shoes?
□ Yes, since _____
□ Left
□ Right
□ No not anymore, since _____
□ No, never has.

Do you play an instrument? (If wind instruments please indicate)
□ No
□ Yes
_____

Did you wear braces?
□ No
□ Yes, as a child and teenager
□ Yes, as an adult

As a child or later in life have you been in treatment by a speech therapist?
□ No
□ Yes

During night, do you sleep with…
□ a closed mouth?
□ an open mouth?

Did you or do you wear 'grinder braces'?
□ No
□ Yes, I do
□ Yes, I did. When? _____

Have you been treated or are you currently in treatment by an Ear-Nose-and-Throat-Specialist?
□ No
□ Yes, for the following reason: _____

Is a longer stay outside of Frankfurt planned?

□ No
□ Yes, When? _____

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Date ***Signature***