ANA POHLMANN
Kieferorthopädie

Informationsheet
for adults

Welcome

to our orthodontical practice in Nürtingen. We would like to take a moment to discuss your orthodontical wishes. For the consultation appointment, we will need your personal medical information. **Of course, your informations will be kept confidential.**

Patient information

Last Name: First Name:
Date of Birth: Health insurance:
Street/No.: Phone:
City/ZIP: Cellphone:
E-mail: Profession:

Insurance

☐ health insurance ☐ private health insurance
☐ medical benefits ☐ additional insurance for orthodontists

Recall?

☐ yes ☐ no If so: ☐ e-mail ☐ text message ☐ phone

We will try to make your stay as enjoyble as possible.

These informations are needed for a trustfull cooporation and treatment. All the personal information will be kept confidential according to §203 and the strict regulations of the data protection law. Modern othodontical treatments need a strong teamwork between patient and orthodontist. Our partial services are provided by trained dental assistents, after prior arrangement by the practitioner and under his supervision. Please let us know if there are any existing x-rays in the jaw area.

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Medical history evaluation
for adults

Please, help us so we can get to know you better!

Why did you come to us today and what can we do for you?

Are you in medical treatment? ☐ yes ☐ no

If so, why?

Who is your family doctor? (name, adresse, phonenumber)

Who is your dentist? (name, adresse, phonenumber)

Are there any other known diseases or infections? ☐ yes ☐ no
(such as heartdieases, Diabetes or Hepatitis)

If so, which disease?

Do you take any medication regularly? ☐ yes ☐ no

If so, which medication?

Do you have any allergies or sensitivities
against any medication or materials? ☐ yes ☐ no

If so, which allergies/sensitivities?

Do you get any x-ray of the head, jaw or tootharea in the last year? ☐ yes ☐ no

If so, where?

Notice: Our modern equipment ensures a small amount of radiation!

For women: Is there currently a known pregnancy? ☐ yes ☐ no

Have you previously been treated by an orthodontist? ☐ yes ☐ no

If so, which doctor?

Do you have any discomfort in the joint of your jaw? ☐ yes ☐ no

Do you grind or clench your teeth? ☐ yes ☐ no

Are there frequent colds or do you snore often? ☐ yes ☐ no

Have you had any accidents where the teeth/jaw has been involved? ☐ yes ☐ no

Is there a misalignment of the teeth or jaw in the family? ☐ yes ☐ no

Is there an existing problem with your speech or pronounciation? ☐ yes ☐ no

How often do you brush your teeth? a day

Do you go to the dentist regularly? ☐ yes ☐ no

Date, signature

Einverständniserklärung

zur Erhebung und Übermittlung von personenbezogenen Patientendaten

Patientendaten

Name: Vorname:

Geburtsdatum: Telefon:

Straße, Nr.: Mobil:

PLZ/Ort:

Ich erkläre mich einverstanden, dass die Praxis Ana Pohlmann …

1. Behandlungsdaten und Befunde **bei anderen Ärzten und Leistungserbringern** zum Zwecke der Dokumentation und weiteren Behandlung **anfordert**.
2. Behandlungsdaten und Befunde an mich **behandelnde andere Ärzte** und **Leistungserbringer übermittelt**.
3. Behandlungsdaten **an zahnmedizinische Labore** zur Herstellung von **kieferorthopädischen Arbeiten** (Kiefermodellen und Zahnspangen) übermittelt.

Einwilligung beim Wechsel der kieferorthopädischen Praxis

Ich bin damit einverstanden, dass die Praxis Ana Pohlmann meine Unterlagen von meiner bisherigen kieferorthopädischen Praxis anfordern darf.
Wenn ich die kieferorthopädische Praxis wechseln möchte, bin ich damit einverstanden, dass die Praxis Ana Pohlmann meine Unterlagen an die neue kieferorthopädische Praxis übermittelt.

Hinweis zur jederzeitigen Widerrufbarkeit

Es ist mir bekannt, dass ich diese Erklärung jederzeit ganz oder teilweise für die Zukunft widerrufen kann

Ort/Datum

Unterschrift des Patienten bzw. des gesetzl. Vertreters