

# Praxis für Zahnheilkunde

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DENTAL PRACTITIONER

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DEAR PATIENT,

Thank you for choosing my practice for your dental health needs. This practice runs an appointments system, meaning that waiting times are, as a rule, kept short. Occasionally patients require urgent yet unforeseen dental treatment, which can lead to a slippage of the appointments schedule. We will let you know quickly should such a slippage affect your appointment time, and we ask for your understanding. If you cannot keep an appointment with us, please cancel it in good time, that is to say, at least 24 hours in advance. If you visit the practice with an unforeseeable emergency (such as acute pain), please reckon with having to wait to be seen.

If you have statutory health insurance, you must present your insurance card to us within ten days of the start of treatment, as the costs for this treatment will otherwise be invoiced privately.

Patient

Surname ----- First name ----- Date of birth -----

Address

Street / house number ----- Tel./mobile no. -----

Postcode / Town ----- Email -----

Insured person /  
payer  
(if different)

Surname ----- First name ----- Date of birth -----

Street / house number ----- Tel./mobile no. -----

Postcode / Town ----- Email -----

Name of the payer

Statutory or private health insurer

I am compulsorily insured  
reimbursement  I am voluntarily insured  I have private supplementary insurance  I am eligible for cost

I am privately insured  I am eligible for a health insurance subsidy (Beihilfe)  I have basic tariff insurance coverage

Occupation of the insured person -----

School pupil / Student

Employer -----

Employer's address

Street / house number ----- Tel. -----

Postcode / Town ----- Email -----

How or from whom did you hear about my dental practice? -----

Compensation of costs for missed appointments

As you can see from our short waiting times, we always try to offer appointments that are adequately long and that dovetail seamlessly with your own schedule. This means, however, that if you cancel with little notice, no other patient will be able to be treated in your allotted time slot. Since health insurers pay only for services provided, we will invoice you privately at 80 per scheduled half hour in accordance with Sections 611 ff BGB, Section 615 Paragraph 1 in particular, for any appointment that you cancel with less than 24 hours' notice. Please be sure, therefore, to cancel any appointment reasonably early. By doing this you will help us maintain our generally short waiting times.

I have read and understood the provision regarding the compensation of costs.

**We request the following information for your patient file. This information is, of course, covered by medical confidentiality. Please also inform us of any future changes to your state of health, your address, or your insurance status.**

1. Do you have / Have you ever had:

- Asthma/(Respiratory difficulties)
- Diabetes
- Rheumatism
- Blood disorders
- Bleeding disorders
- HIV infection
- Tumor growth

- Liver disease
- Tuberculosis
- Hepatitis A/B/C (Jaundice)
- Seizures (Epilepsy)
- Thyroid disorders
- Kidney failure
- Osteoporosis

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Allergic reactions / Drug or substance intolerance

No

If yes, to what? .....

- 
- Heart attack
  - Stroke
  - Paralysis

Do you take Marcumar or Coumadin?

Yes

No

If yes, when? .....

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How high is your blood pressure?

Low

Normal

High

Blood pressure reading, if available: .....

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2. Are you fitted with a pacemaker?

Yes

No

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3. Do you regularly take medications?

Yes

No

If yes, which? .....

Do you regularly receive infusions?

Yes

No

If yes, what kind? .....

Do you take bisphosphonates?

Yes

No

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4. Are you pregnant?

Yes

No

Uncertain

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5. Other information / Other medical conditions

.....  
.....

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6. Do you smoke?

Yes

No

If yes, how much do you smoke? .....

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7. Do you have an X-ray record card?

Yes

No

If not, you can ask at the reception and we will be happy to provide you with one.

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8. I am interested in the dental prophylaxis (professional teeth cleaning) recall program

Yes

No

Not sure

You can ask at the reception for more information.

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With my signature I confirm the completeness and correctness of the information that I have provided overleaf and above

.....  
Date

.....  
Signature patient / legal representative