DR. STREUBEL & PARTNER /
SPECIALISTS IN DENTAL AND ORAL MEDICINE

WELCOME /

Dear patient,

Before we can focus on your dental requests and problems, we require your personal details, as well specific information on your general state of health. This is the only way to ensure appropriate, risk-free treatment. All information will be kept confidential as required by law.

LAST NAME / .....
FIRST NAME / .....
DATE OF BIRTH / .....
STREET / HOUSE NO. / .....
CITY / POST CODE / .....
TEL: HOME / .....
TEL: MOBILE / .....
TEL: WORK / .....
NATIONALITY / .....
EMAIL / .....
ID NO. / .....
HEALTH FUND / INSURANCE / .....
ADDITIONAL INSURANCE / .....
PRIMARY POLICYHOLDER (FOR CHILDREN) / .....

Would you like to be reminded about your next check-up?

YES ☐
NO ☐

How did you hear about us?

RECOMMENDATION ☐
INTERNET ☐
TELEPHONE BOOK ☐

Our practice operates based on an ordering system, i.e. we arrange appointments geared around your requirements wherever possible in order to save you long waiting times. Multiple hours are booked for extensive treatments so as to avoid running short of time. Please therefore cancel any appoints you are unable to make at least 1-2 days in advance.

Thank you!

DATE / SIGNATURE /

10, RUE DE SCHEUERHOF / 5412 CANACH, LUXEMBOURG / TEL: +352-2670 1371 / INFO@DR-STREUBEL.COM / WWW.DR-STREUBEL.COM

MEDICAL HISTORY /

Dear patient,

Thank you for placing your trust in our practice. Please complete this form carefully; it will help ensure your treatment is more personalised and tailored to your requirements. Please immediately advise us of any changes to the information below. We thank you for your co-operation.

GP / Specialist / .....
Address / .....
Telephone / .....

TREATMENTS /

Are you currently undergoing medical treatment? ... yes/no
If so, for which illness? .....

HEART DISEASES /

Cardiac insufficiency? ..... yes/no
Irregular heartbeat (arrhythmia)? ..... yes/no
Angina? ..... yes/no
Pacemaker or artificial heart valve? ..... yes/no
Previous endocarditis? ..... yes/no
Other? .....

METABOLIC DISEASES /

Diabetes? ..... yes/no
Gastrointestinal disorders? ..... yes/no
Thyroid diseases (overactive/underactive)? .....
..... yes/no
Other? .....

BLOOD DISORDERS /

Haemophilia? ..... yes/no
Anaemia? ..... yes/no
Other? .....

INFECTIOUS DISEASES /

HIV? ..... yes/no
Hepatitis A / B / C (liver inflammation, jaundice)? .... yes/no
Tuberculosis? ..... yes/no
Chronic airway disorders, cough etc.? .....
..... yes/no
Other? .....

X-RAYS /

Have you undergone a head, jaw or throat X-ray in the last year? ..... yes/no
If so, where? .....

MEDICATIONS /

Which medications do you take regularly?
.....

CIRCULATORY DISORDERS /

High blood pressure (hypertension)? ..... yes/no
Low blood pressure? ..... yes/no
Previous heart attack? ..... yes/no
Do you take blood-thinning medication? .....
..... yes/no
Other? .....

ALLERGIES /

Which materials or medications are you hypersensitive to?
.....
Do you have an allergy card? ..... yes/no
Do you suffer from asthma? ..... yes/no

NERVOUS SYSTEM DISORDERS /

Epileptic fits (epilepsy)? ..... yes/no
A tendency to cramp? ..... yes/no
Other? .....

AUTONOMIC DISORDERS /

Fainting? ..... yes/no
Do you take stimulants or sedatives? ..... yes/no
Other? .....

PREGNANCY / yes/no

If so, how many months? .....

OTHER INFORMATION /

Do you have a drug addiction? ..... yes/no
Do you have an alcohol addiction? ..... yes/no
Do you smoke? ..... yes/no

DATE / SIGNATURE /