DR. MICHAEL MARZELLUS
GOMOLKA
KIEFERORTHOPÄDIE

Dear patient!
Welcome to our Office. Please answer the following questions about your state of health as accurately as possible.
The information collected is subject to medical privacy and data protection laws and will be kept strictly confidential.

ADULT QUESTIONNAIRE

Last name, first name: _____

Date of birth: _____ ☐ female ☐ male ☐ nationality _____

Street, number: _____ Postal code: _____ City: _____

Phone (home): _____ Phone (work): _____

E-mail Address: _____ Occupation: _____

Would you like to get a reminder for your appointment? ☐ no ☐ yes

Preferred contact method: ☐ SMS ☐ E-Mail ☐ phone

Insurance information:

☐ Private insurance: _____ ☐ Basic or standard rate? _____

☐ Statutory insurance: _____ ☐ compulsorily insured ☐ voluntarily insured ☐ entitled to aid

Dentist name: _____

How did you hear about our Office? ☐ Dentist ☐ Internet ☐ Ad ☐ Practice signs ☐ Family or Friend

☐ other: _____

Have you ever received orthodontic treatment? ☐ no ☐ yes where? _____

Have you ever consulted an orthodontist? ☐ no ☐ yes where? _____

Have you had dental x-rays? ☐ no ☐ yes where? _____

Have you ever been treated for any of the following? ☐ no ☐ yes where? _____

☐ Heart disease ☐ Diabetes ☐ Infectious disease (HIV, Hepatitis, Tuberculosis) ☐ Colds

☐ Asthma/Lung disease ☐ Rheumatism ☐ Epilepsy ☐ Blood disorder ☐ Hepatitis/Liver disease

☐ Thyroid disease ☐ other: _____

Are you allergic to any medication? ☐ no ☐ yes (nickel, latex) _____

Are you taking any medication? ☐ no ☐ yes which? _____

Have you ever had an injury to teeth, mouth or chin? ☐ no ☐ yes when? _____

Are you pregnant? ☐ no ☐ yes

What would you like orthodontics to accomplish?

☐ straight teeth ☐ long-term health of teeth ☐ better chewing capacity

☐ improve general appearance ☐ improve speech ☐ eliminate pain

What don't you like about your teeth or bite?

_____

The information above is correct and the insurance information is complete. I agree to immediately report any and all changes arising during the entire treatment period.

Stuttgart, _____
(Date / Signature)

clear send