REGISTRATION

PLEASE FILL OUT AND SUBMIT BEFORE THE TREATMENT!

Dear Patient,

You come for dental treatment in a practice that is run according to the ordering system. This usually means only short waiting times for you. This also means that if you cannot keep the agreed appointment, you must cancel at least 24 hours in advance, otherwise you will be charged for the planned work or unused time (§§ 304, 615 BGB). If you receive an emergency appointment due to an emergency, you must expect a waiting time. If this appointment is outside of our consultation hours, only emergency care is possible.

Important for patients with statutory health insurance:

If the health insurance card is not submitted no later than 10 days after the treatment appointment, or you will be obliged to pay a bill on your own

patient: _____
lastname forename birthday

address: _____
street, No. postcode, city

telephone numbers: _____
mobile number

payer: _____
see note on back

occupation of the payer: _____

Insurance: _____

Insurance status: ❒ privately insured ❒ statutory health insurance
❒ voluntarily insured ❒ private supplementary insurance
❒ I would like to receive private treatment

We ask for the following information for your medical record, which is of course subject to medical confidentiality:

1. Do you have any of the following diseases?

a) Asthma (severe shortness of breath) ❒ yes ❒ no
b) allergic reactions (such as hay fever) ❒ yes ❒ no
c) Intolerance to medication ❒ yes ❒ no
If so, which ones: _____
d) Blood pressure ❒ low ❒ normal ❒ high
values: _____
e) ❒ heart attack ❒ stroke ❒ paralysis ❒ heart disease
when: _____

please turn over 1 / 2 >>

f) ❒ jaundice ❒ HIV-Inf./AIDS ❒ liver disease ❒ tuberculosis ❒ no

when: _____

g) diabetes ❒ yes ❒ no

h) rheumatism ❒ yes ❒ no

i) ❒ blood disorder

❒ blood clotting disorders

j) circulatory disease ❒ yes ❒ no

k) kidney disease ❒ yes ❒ no

l) thyroid disease ❒ yes ❒ no

m) epilepsy ❒ yes ❒ no

m) osteoporosis ❒ yes ❒ no

when? _____

2. Currently take or take medication regularly? ❒ yes ❒ no

3. Are you or have you been undergoing chemotherapy, bisphosphonates or radiation therapy? ❒ yes ❒ no

4. Do you wear a pacemaker? ❒ yes ❒ no

5. Do you suffer from bleeding gums? ❒ yes ❒ no

6. When was the last x-ray examination? _____

7. Is there a pregnancy? ❒ yes ❒ no

How many weeks? _____

8. Other information/other diseases:

_____

_____

9. How did you find out about our practice?

_____

_____

With my signature, I confirm the completeness and correctness of my information.

_____

date Signature

Please continue to inform the practice of any changes in your state of health and address.

NOTE:
In the case of adult co-insured persons, the payer (= invoice recipient) is the above-mentioned patient; in the case of minors, the legal representative.