



Registration form

Patient

Family Name

First Name

Date of birth

Address

.....

.....

Phone / private

Phone / work

Mobile phone

E-Mail.....

Profession

Employer

Assured person

Family Name

First Name.....

Date of birth.....

Address

.....

.....

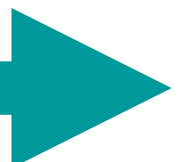
Assurance

Statutory health insurance Private insurance Allowance Additional insurance
 (only basic rate?)

Information on your current health

	yes	no		ja	nein
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Drug hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting tendency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in shoulders or spinal column	<input type="checkbox"/>	<input type="checkbox"/>			
Headache frequently	<input type="checkbox"/>	<input type="checkbox"/>			
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>			
Grinding / pressing of teeth	<input type="checkbox"/>	<input type="checkbox"/>			
			Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
			Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>
			Blood disease	<input type="checkbox"/>	<input type="checkbox"/>
			HIV pos. / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Do you feel like your teeth do not fit to each other?	<input type="checkbox"/>	<input type="checkbox"/>
			Pain of Masticatory muscle	<input type="checkbox"/>	<input type="checkbox"/>
			Problems with	<input type="checkbox"/>	<input type="checkbox"/>
			Temporomandibular joint		

PLEASE FILL IN THE REVERSE SIDE AS WELL.



Special questioning

What's the current matter of your appointment?

- General check-up
- Pain
- Bleeding of gum
- Defects of dentures
- New dentures necessary
- Consultation desired
- Aesthetic improvement desired
- Other reasons

We developed a Recall-System to remind our patients of their appointments. If you are **NOT INTERESTED** in taking part in this system, please mark a cross.



Do you have a family doctor?

If yes:

Name

Phone number

How did you took notice of our practice?

.....

Comment: All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential. No external person will get access to your data without permission.

Private treatment is accounted with a private bill in case of a missing insurance card. The card or treatment form has to be presented within 10 days after the appointment. If you can't make it, please cancel the appointment within 24 hours before it's due. Otherwise you have to pay for the wasted time (§§ 304, 615 BGB).

Date

Signature

Thank you for answering our questions.