PATIENT REGISTRATION FORM

Welcome to our practice!

▶ ▶ ▶ PLEASE PRINT CLEARLY! Thank You

____

patient (last name, first name) Mr. Mrs. Ms. Miss Dr. date of birth

____

postal address street name and house number city and zip code

______________________________________(______)____________________________

country phone number email

______________________________________ ☐ employee ☐ self-employed

occupation

____

employer zip code city

are you insured? ☐ yes ☐ no german insurance company ☐ yes ☐ no

____

dental insurance company (Krankenkasse) located in policy number

Are you presently under the care of a physician? ☐ yes ☐ no ______________________________

name, adress and phone of the physician

MEDICAL HISTORY

The purpose of the following questionnaire is to determine possible risks. Please answer conscientiously on behalf of your own safety. Your answers will be treated according to medical secrecy. Should any points be unclear, please ask my staff for help.

	Yes	No
1. Do you suffer from any heart-, circulatory- or vascular diseases?	☐	☐
2. Do you suffer from any respiratory diseases?	☐	☐
3. Do you have any blood diseases or high bleeding risks (e.g. clotting factor disease)? Do you take any of this medication: Warfarine, Marcumar, Falintrom or other coumarine derivates which can induce a high potential of bleeding ? If yes please specify ______________	☐	☐
4. Do you suffer from diabetes?	☐	☐
5. Do you take medication on a regular basis? If so, please list any medications, including non-prescription, which you are currently taking ______________	☐	☐
6. Do you suffer from any allergies? If so, please list them ______________	☐	☐
7. Do you/did you suffer from any liver diseases (e.g. Hepatitis)?	☐	☐
8. Do you/did you suffer from Tuberculosis (TBC)?	☐	☐
9. Do you suffer from AIDS (HIV)?	☐	☐
10. Do you suffer from any rheumatic diseases?	☐	☐
11. Are you pregnant?	☐	☐
12. Are you afraid of the dental treatment? If so, in what degree ☐ a little ☐ reasonably ☐ a lot	☐	☐
13. Do you have toothache?	☐	☐
14. Do you wish to be treated under local anesthesia?	☐	☐
15. Do you have problems/pain with your jaws?	☐	☐
16. Do you have ever been treated orthodontically?	☐	☐
17. Do you sometimes have bleeding of the gums?	☐	☐
18. How did you find our office? (Refferal Source) ______________		

I attest to the accuracy of the information on this form and hereby authorize the dental staff to perform necessary dental treatment mutually agreed upon by me as may be required for proper dental care.

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Date Signature