Patient **R**egistration **F**orm

Dear patient,
thank you for choosing our office for your dental care needs; we appreciate the opportunity to help you further. If you put emphasis on a professional and experienced team, as well as on a sound individual treatment concept, then you are right at home with us. Our team is proud to be your reliable partner and help you achieve your dental health goals. **If you can't keep the appointment please make a cancelation at least 24 hours in advance.** *Thank you for your understanding!*

What is the reason for your visit?

☐ Check Up (Kontrolle) ☐ Consultation (Beratung) ☐ Cleaning (Zst) ☐ Gum bleeding (Mu) ☐ TMJ issues (KG)

☐ Toothache (Zahnschmerzen) ☐ Problems with the dental work (crown, bridge) (ZE-Probleme) ☐ Others

Patient ☐ Male ☐ Female ☐ Child / ☐ Kindergarten ☐ School / ☐ Student

Last Name | First Name | Date of Birth

Street Name and House No. | ZIP Code | City

Phone No. | Mobile Phone | Email

Insurance Holder (For minor children usually one of the parents or the legal guardian) ☐ Male ☐ Female ☐ The same as the Patient

Last Name | First Name | Date of Birth

Street Name and House No. | ZIP Code | City

Phone No. | Mobile Phone | Email

Medical Insurance Plan

☐	German public insurance (E.g. AOK, TK, BKK, DAK)	Gesetzliche Krankenversicherung
☐	German private insurance	Private Versicherung
☐	European Health Insurance Card (EHIC)	EU Krankenversicherung
☐	Student Insurance Plan	Studenten Versicherung
☐	No insurance at all or other non european insurance plan	Ich bin nicht versichert oder habe eine non EU Versicherung

Versichertenstatus

Dental Insurance Company

Occupation | Employer

If you have a German public insurance plan you are obliged to show the insurance card at each visit to the doctor. If the card is not being shown within 10 days of treatment, we are entitled by law to bill you for the entire costs of the treatment.

How did you find our office (Refferal Source)? Reffered by .....

☐ Google ☐ Facebook ☐ Other Website ☐ Office sign ☐ Refferal

Are you afraid of the dental treatment? ☐ No ☐ Yes If yes, please check the intensity on the scale below

0 No fear at all 1 2 3 4 5 6 7 8 9 Dental Phobia 10

Patient **R**egistration **F**orm

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 confidentiality and data protection laws. Should any points be unclear, please ask the doctor or the staff for help. Please also tell us future changes in your health status, address and state of insurance. *Thank you!*

		Yes	No
Heart/Circulatory System	Heart attack *If yes please tell us the year: .....*	☐	☐
	High blood pressure *If yes please tell us the average values .....*	☐	☐
	Infectious endocardytis	☐	☐
	Heart failure	☐	☐
	Do you have a cardiac pace maker?	☐	☐
	Arrhythmias or fibrillation	☐	☐
	Angina pectoris	☐	☐
Blood coagulation	Anticoagulant therapy? *If yes please check below and tell us the last INR value .....*	☐	☐
	Please check if you take one of the following medications: ☐ Marcumar ☐ ASA ☐ Aspirin ☐ Iscover ☐ Plavix ☐ Eliquis ☐ Pradaxa ☐ Xarelto		
Hematologic Diseases	Hemophilia, Trombocytopenia, von Willebrand disease or similar	☐	☐
	Anemia	☐	☐
Metabolic Diseases	Diabetes	☐	☐
	Hypothyroidism or Hyperthyroidism	☐	☐
	Rheumatism	☐	☐
	Osteoporosys	☐	☐
	If yes did you or do you take: Fosamax, Fosavance, Actonel, Bonviva, Zometa, Aclasta or similar?	☐	☐
Infectious Diseases	Hepatitis Type ☐ A ☐ B ☐ C	☐	☐
	Tuberculosis (TBC)	☐	☐
	AIDS (HIV)	☐	☐
Nervous System Diseases	Stroke *If yes, please tell us the year .....*	☐	☐
	Epilepsy	☐	☐
	Paralysis	☐	☐
	Mental illnesses, E.g.: depression, anxiety, phobia, general anxiety disorder	☐	☐
Allergies/Intolerances	Drug or non-drug intolerance?	☐	☐
	Allergies? *If yes please list : .....*	☐	☐
Medication	Do you take medication on a regular basis? *If yes please list .....*	☐	☐
Drugs	Do you take or have taken drugs in the past?	☐	☐
For our female patients	Are you pregnant? *If yes, please tell us the month .....*	☐	☐

Other information that you consider important:

If you are under care of a physician: Name of the physician City Phone

	Yes	No
Would you like to have a professional dental cleaning? (PZR)	☐	☐
Are you interested in a consultation for dental work like crowns, bridges, implants, dentures (ZE-Beratung)	☐	☐
In case you need fillings should we use only tooth coloured fillings? Additional charges may apply (MKV)	☐	☐
Do you need a cosmetic dental treatment like veneers, bleaching, smile makeover? (Zahnverschönerung)?	☐	☐
Would you like to have a high quality tretment even though this would cost you more than regular treatment?	☐	☐
Would you like to remind you for the next check up, usually within 6 months? (Recall)	☐	☐

I certify that I have read and fully understood the above and declare that the information provided by me in this questionnaire are true and complete. I take full responsibility for incidents or complications that may occur in the event that such information was false or incomplete. I hereby authorize the dental staff to perform necessary dental treatment mutually agreed upon by me as may be required for proper dental care.

_____ _____

Location/Date (dd/mm/yyyy) Patient signature. For minor children signature of the parents or legal guardian