

Welcome to our practice

Patient Registration Form



Landstuhler Straße 26a · 66877 Ramstein
Tel.: 06371/71 538 · Fax: 06371/57 404

Patient (family name, first name)

Date of Birth

Insurance Member

Date of Birth

Street

Postcode

City

Insurance

Profession

Employer

Phone Number (private/mobile) (workplace)

Anamnesis

Please answer the following questions.

All information is subject to the legal requirement concerning confidential medical communication.

Who is your general practitioner?

Are you currently taking medication? ☐ yes ☐ no

If yes, please specify.

Are intolerant to certain medication (e.g. penicillin)? ☐ yes ☐ no

If yes, please specify.

Have you been x-rayed at head or jaw in the last 12 months? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no

Heart disease/Circulatory disorder ☐ yes ☐ no

Heart pacemaker/Cardiac valve replacement ☐ yes ☐ no

Are you taking any medication to hinder blood clotting? ☐ yes ☐ no

Allergies (e.g. hay fever) ☐ yes ☐ no

Diabetes ☐ yes ☐ no

Contagious diseases (e.g. TB, jaundice, HIV) ☐ yes ☐ no

Rheumatism ☐ yes ☐ no

Liver disease ☐ yes ☐ no

Thyroid disease ☐ yes ☐ no

Osteoporosis ☐ yes ☐ no

medication for Osteoporosis (bisphosphonates) ☐ yes ☐ no

other diseases? ☐ yes ☐ no

If yes, which?

Gum bleeding ☐ yes ☐ no

Do you appreciate local anesthesia? ☐ yes ☐ no

Would you like to be reminded of your regular check-ups **(recall)**? ☐ yes ☐ no

If yes, email-address:

Do you wish information on:

Prophylaxis ☐ yes ☐ no

Professional tooth cleaning ☐ yes ☐ no

Bleaching ☐ yes ☐ no

Implants ☐ yes ☐ no

Dentures ☐ yes ☐ no

In which way did you take notice of our practice?

Please be advised;

In case that you cannot make your appointment, it has to be canceled within 24 hrs to your appointment. If appointments are not canceled within that time we will have to bill you with any arisen costs.

Date

Patient signature