

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.

Are you currently under medical treatment? yes no

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

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

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 notify us timely if you cannot stick to your appointment.

Date _____ Patient signature _____