Registration

Please fill out and submit this form before your treatment!

Patient First name, last name	Date of birth, place of birth
Address Street, house no.	Postcode, town
Phone	Email
Payer* First name, last name	Date of birth, place of birth
Address Street, house no.	Postcode, town
Phone	Email

Please note: The payer (= recipient of invoice) should be the patient identified above for co-insured patients above legal age or their legal representative for minors.

Name of health insurance

Profession of payer

☐ private insurance
☐ compulsory insurance
☐ voluntary insurance
☐ private supp. insurance

☐ I would like private treatment (reimbursed under Section 13(2) SGB V)
☐ I require care
level of care _____
☐ I receive integration support (under Section 53 SGB XII)

Name of employer	Postcode, town
Address of employer Street, house no.	Phone

Dear patient, welcome to our practice!
This dental treatment practice works according to a booking system. This means that your waiting times will usually be short. However, it also means that you must cancel at least 24 hours in advance if you cannot keep your appointment, otherwise you will be billed for the planned work or unused time (Sections 304, 615 BGB). If you make an emergency appointment for an emergency, please expect some waiting time. If the appointment is outside of office hours, only emergency care is possible.

Notice for legally insured patients:
If you do not submit your health insurance card within 10 days of the start of treatment, your invoice will be billed privately.

The following details are requested so that we can prepare ourselves for your appointment. This information is naturally covered by medical confidentiality. Please keep us informed of any changes in your health status and contact details in future!

1. Have you had / do you have any of the following conditions?
   - a) Asthma (severe breathing difficulties) ☐ yes ☐ no
   - b) Allergic reactions, e.g. hay fever ☐ yes ☐ no
   - c) Medication intolerance ☐ yes ☐ no
     if yes, which? _____
   - d) Blood pressure ☐ low ☐ normal ☐ high
     if applicable, values? _____
   - e) ☐ Heart attack ☐ Stroke ☐ Paralysis
     ☐ Heart disease ☐ no
     if yes, when? _____
   - f) ☐ Jaundice ☐ Liver disease ☐ HIV ☐ no
     if yes, when? _____
   - g) Diabetes ☐ yes ☐ no
   - h) Rheumatism ☐ yes ☐ no
   - i) Blood disorders ☐ yes ☐ no
     Bleeding disorders ☐ yes ☐ no
   - j) Circulatory disorders ☐ yes ☐ no
   - k) Kidney disease ☐ yes ☐ no
   - l) Thyroid disease ☐ yes ☐ no
   - m) Epilepsy ☐ yes ☐ no
   - n) Osteoporosis ☐ yes ☐ no
   - o) Tumour disease / cancer ☐ yes ☐ no

2. Do you have a pacemaker? ☐ yes ☐ no
3. Do you suffer from gum bleeding? ☐ yes ☐ no
4. Do you strongly prefer treatment under local anaesthesia? ☐ yes ☐ no
5. When was your last X-ray examination? _____
6. Are you currently or regularly taking medication? ☐ yes ☐ no
   if yes, which? _____
7. Are you pregnant? ☐ yes ☐ no ☐ unknown
   if yes, how many weeks? _____
8. Are you currently breastfeeding? ☐ yes ☐ no
9. Would you like any fillings to match teeth colour? ☐ yes ☐ no
10. Do you like the colour of your teeth? ☐ yes ☐ no
11. Other information / other conditions

12. How did you hear about our practice?

Date, patient signature