MKG | RÖDINGSMARKT
DR. PREUSSE & DR. WIELAND

Registration form with anamnesis

Dear Patient,

Welcome to our practice. For optimal treatment results, answering questions about your health carefully is particularly important.

All information is of course subject to the medical confidentiality of the dentist and the entire team. Thank you for your cooperation.

Patient

Name: _____

First name: _____

Birthday: _____

Adress: _____

_____

Main insured person (if not patient himself)

Name: _____

First name: _____

Birthday: _____

Adress: _____

_____

Contact

Telefon (privat): _____

Mobil: _____

E-Mail (privat): _____

Bill recipient (if not the patient himself)

Name: _____

First name: _____

Adress: _____

_____

Profession: _____

Health insurance: _____

Who is your treating dentist or referrer?

_____

_____

_____

Do you have a family doctor? If yes, which one?

_____

_____

_____

Are there any health risks? ☐Yes ☐No

If yes, which? _____

Do you suffer from an allergy? ☐Yes ☐No

If yes which? _____

Do you have ...

a stomach/ intestinal disease? ☐Yes ☐No

A heart/ circulatory disease? ☐Yes ☐No

Coagulation disorders? ☐Yes ☐No

High blood pressure? ☐Yes ☐No

Low blood pressure? ☐Yes ☐No

Diabetes? ☐Yes ☐No

A kidney disease? ☐Yes ☐No

Glaucoma? ☐Yes ☐No

Have you had cancer? ☐Yes ☐No

Have you ever received bisphosphonates (e.g. osteoporosis or as part of cancer)? ☐Yes ☐No

Do you wear a pacemaker? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

If yes, which week? _____

Do you suffer...

from osteoporosis? ☐Yes ☐No

from a thyroid disease? ☐Yes ☐No

from migraines ☐Yes ☐No

from rheumatisnm/ arthrosis? ☐Yes ☐No

Do you have ...

an infectious disease? ☐Yes ☐No

☐HIV ☐Hepatitis B ☐Hepatitis C

☐Other: _____

Autoimmune diseases? ☐Yes ☐No

Do you take any medcine?

If yes, which? _____

Do you smoke? ☐Yes ☐No

We would like to point out that, according to Section 615 BGB, surgery appointments that are not kept can be billed. **We therefore ask you to cancel appointments 48 hours in advance by telephone or email.**

With my signature I confirm the accuracy of my information.
I hereby agree that my treatment-related data may be stored within the practice exclusively for the purpose of medical/dental treatment and may be passed on to the doctors, dentists or laboratories involved in the treatment. This consent can be revoked at any time.

Hamburg, _____ **Signature:** _____