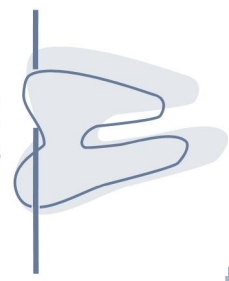


REGISTRATION FORM

Dr. Martin Braun
Zahnarzt



_____	_____	_____	_____
Patient: Surname, First Name	Place of Birth	Date of Birth	Nationality
_____	_____	_____	_____
Street, No.	Zip-Code, City	Phone / Fax	

_____	_____	_____	_____
Insured Person: Surname, First Name	Place of Birth	Date of Birth	Nationality
_____	_____	_____	_____
Street, No.	Zip-Code, City	Phone / Fax	

Health Insurance

*) Patients have to pay the costs for medical treatment by themselves, if the insurance document (Health Insurance Chip Card) is not shown to our reception between ten days.

Do you have a special teeth insurance or another agreement for meeting the costs of your medical treatment? yes no

Occupation	Employer	Phone / Fax
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How have you been noticed about our office? _____

Why did you come?

Do you want to be remembered for check-up appointments (Recall)? yes no

Do you only want to be treated by your toothache? yes no

Do you want special informations about:

- Caries- and Parodontitisprevention
- Prevention for mother/children
- Parodontitistreatment
- Esthetic Fillings/Crowns
- Goldfillings
- Tooth replacement
- Bleaching
- Mercuryremoving
- Implants

Something else? _____

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Zahnärztin Dr. Claudia Scharff, angestellt
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Please answer the following questions:

yes no

1. Are you being treated by a doctor?

In case of yes, who is the doctor? _____

Do you take drugs regularly?

In case of yes, which ones? _____

Do you have allergic or hypersensitive reactions? Penicillinallergy?

In case of yes, for what? (Allergymap?) _____

2. Do you tend to bleed heavily after injuries? Haemophiliac deseases?

3. Do or did you suffer from the following deseases?

Heart disease or circulatory trouble, cardiac valve prostheses,
angina pectoris, endocarditis

Infektions desease (tuberculosis, hepatitis, aids/HIV)

Cataract (glaucoma)

High bloodpressure Low bloodpressure

Bloodless (anemia)

Epileptic

Asth

Kidneytrouble

Liverdesease

Diabetes

Thyreoidhyperfunction

4. Do you have any different illness?

In case of yes, which one? _____

5. Do you have a cardiac rhythm machine?

6. For female patients. Are you in pregnancy or nurse time?

7. When was the last X-ray taken? _____

8. Are you smoking?

City, Date

Signature

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