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

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?

Zahnarzt Dr. Martin Braun
Zahnärztin Dr. Claudia Scharff, angestellt
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Jasperallee 25 – 38102 Braunschweig
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www.zahnarzt-martin-braun.de

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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