ZAHNÄRZTE
AN DER ELBESTRASSE

Patient Registration Form

Surname: _____ First Name: _____
Date of Birth: _____ Nationality: _____
Country/City of Origin: _____
Language Skills: _____

For Minors Only
Legal Guardian
Surname: _____ First Name: _____
Date of Birth: _____ Nationality: _____

Contact Details
Phone / Mobile Number: _____
E-Mail: _____
Current Address (Street/No./City): _____

Phone No. of Interpreter/Translator _____

Please answer the following questions about your health as accurately as possible!
The information is subject to medical confidentiality and data protection regulations and will be treated in strict confidence.

Heart / Cardiovascular Disease	☐ yes	☐ no
Blood Clotting Disorders	☐ yes	☐ no
Seizure Disorder (Epilepsy)	☐ yes	☐ no
Asthma / Lung Disease	☐ yes	☐ no
Fainting Spells	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Liver Disease / Hepatitis	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no
Rheumatism / Arthritis	☐ yes	☐ no
Thyroid Disease	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no
HIV Infection / AIDS	☐ yes	☐ no
Infectious Diseases (e.g. MRSA)	☐ yes	☐ no
Drug Dependency	☐ yes	☐ no
Smoker	☐ yes	☐ no

Are you pregnant? ☐ yes ☐ no
If yes, which month? ..... Month

Other Conditions: ☐ yes ☐ no
_____
_____
_____
_____
_____

Allergies or Intolerances:

Local Anaesthesia / Injections	☐ yes	☐ no
Antibiotics	☐ yes	☐ no
Painkillers	☐ yes	☐ no

Other: _____

Have dental X-rays been taken of you before? ☐ yes ☐ no
If yes, when? _____

Do you have difficulty chewing due to missing teeth? ☐ yes ☐ no

Have you seen a general practitioner? ☐ yes ☐ no
If yes, which doctor? _____

What medications do you take regularly or currently? _____ since _____
_____ since _____
_____ since _____

_____ , Date _____ Signature: _____