DR. SONJA MÜNCH
ZAHNÄRZTINNEN
DR. ROSWITHA GRAF

REGISTRATION

Patient: Last name | First name | Date of birth

Address | Home phone

Insurant: Last name | First name | Date of birth

Address | Home phone

E-Mail | **Mobile**

Occupation | Employer | Work phone

Address

Insurance: Statutory | Private

Medical history

Are you on any regular medication?	☐ Yes ☐ No
Do you have any allergies?	☐ Yes ☐ No
Do you suffer from heart disease?	☐ Yes ☐ No
Do you have any circulatory problems?	☐ Yes ☐ No
Do you have any metabolie disorders?	☐ Yes ☐ No
Do you have any blood disease?	☐ Yes ☐ No
Do you have any infectious disease?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No

Please note:
We require at least 24 hours notice if you wish to cancel your appointment.
Otherwise we will have to invoice you for the lost time. We appreciate for your understanding.

We do not disclose your personal data. It is protected by doctor-patient-confidentiality through German federal law (§203 StGB) and the strict rules of privacy. We kindly ask you to thoroughly and truthfully fill out this form.
It is our declared endeavour, to make your stay in this dental office as pleasant as possible. In case something seems unsatisfactory to you, please do not hesitate to inform us We can only improve things with your feedback. Thank you.

Date, Signature | Thank you very much for your co-operation. Please inform us of any changes.

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