



ZAHNARZTPRAXIS
DR. SONJA MÜNCH
UND KOLLEGEN

REGISTRATION

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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from heart disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any circulatory problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any metabolic disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any blood disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any infectious disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.