Dr. med. dent. Olaf Siebert
Fachzahnarzt für Oralchirurgie
Tätigkeitsschwerpunkt Implantologie

Schlüterstr. 41 ▪ 10707 Berlin
Tel. 030/88 77 38 34 ▪ Fax 030/88 77 38 36
E-Mail: praxis.siebert@yahoo.de

REGISTRATION

Patient			
Last name, first name:		❑ male ❑ female	Date of birth DD/MM/YY):
Address street:		Postal Code, City:	
Telephone No. Home:	Mobile:	Profession:	Telephone No. Business:
Health Insurance Company:			Your weight (kg):
Additional Dental Insurance*	In effect since (date):	E-Mail:	
Dentist, name and address:		Last X-Ray(s) of skull, jaw or teeth (date):	
Family Doctor, name and address:			
Policy Holder			
Last name, first name:		❑ male ❑ female	Date of birth DD/MM/YY):
Address street:		Postal Code, City	
Telephone No. Home *	Mobile*	Profession*:	Telephone No. Business*:

* if available

Consent according to § 4a Federal Data Protection Law

- I hereby agree to the electronic entry, use and processing of my personal data within the practice according to the data protection laws.
- I hereby allow the practice to request medical information required for my treatment from my dentist, family doctor or other medical professions, and I agree to the documentation and use of these data for my treatment.
- I hereby agree to the transmission of my data and treatment information to my dentist, family doctor or other medical profession (i.e. dental laboratory, pathohistological and/or microbiological laboratory, physiotherapist, speech therapist), if necessary for my treatment.

This agreement can be revoked partly or completely at any given time.

Berlin, (date):

- signature of patient / custodian -

MEDICAL QUESTIONNAIRE

Dear patient,
several diseases may interfer with your dental treatment. Therefore, we kindly ask you to fill in this questionnaire. All information is recorded electronically and is subject to medical confidentiality and data protection. Questions marked * are voluntary. Do you or did you suffer from any of these diseases in the past?

Heart / Circulation
O Heart defect
O Chest pain/Angina pectoris
O Heart attack
O Myocarditis
O Endocarditis
O Artificial heart valves or blood vessels
O Pacemaker
O High blood pressure
O Low blood pressure
O Cardiac arrhythmia
O Heart failure / shortness of breath

other_____

Blood vessels
O Stroke
O Arteriosklerosis
O Thrombose
O Artificial blood vessels
O Bypass-surgery
O Stent implants

other_____

Respiratory system
O Bronchial asthma
O Pneumonia
O Tuberculosis
O Chronic obstructive pulmonary disease
O Pulmonary emphysema

other _____

Liver / Gall bladder
O Jaundice (Icterus)
O Cirrhosis
O Fatty Liver
O Gall stones
O Hepatitis A
O Hepatitis B
O Hepatitis C

other _____

Kidneys
O Nephritis
O Kidney Stones
O Renal insufficiency (Renal Failure)
O Renal dialysis

other _____

Gastrointestinal Disorders
O Gastric ulcer
O Crohn's disease
O Colitis ulcerosa
O Lactose intolerance
O Heartburn
O Functional dyspepsia
O Reflux disease

other_____

Metabolic disorders
O Diabetes mellitus
O Type I O Type II
O Thyroid hypofunction
O Thyroid hyperfunction
O Crop (Struma)

other_____

Skeletal system
O Arthropathy
O Chronic back pain
O Intervertrebral disc lesion
O Muscular diseases (i. e. Amyosthenia)
O Fibromyalgia

other_____

Nervous System / Psyche
O Seizures (Epilepsy)
O Paralysis
O Depression
O Anxiety disorder

other_____

Eyes
O Cataract
O Glaucoma
O Severely reduced sight
O Blindness

other_____

Bleeding disorders
O Bleeding disorders (Haemophilia)
O Frequent nosebleed
O Bruises without injury
O Secondary bleeding after surgery

other_____

Allergies / Hypersensitivity
O Hay fever
O Food allergies
O Iodine
O Latex
O Band-Aid
O Antibiotics (i.e. Penicillin)
O other drugs

Which?_____

O **Are you pregnant?**
Week of pregnancy?_____

Immunity
O Corticoid therapy
O Organ transplant
O HIV positive
other_____

Bone
O Were you ever or are you currently treated with Bisphosphonates ?
Due to what disease?

_____

When?_____

What drug?_____

O **Did you ever have a tumor disease ?**

Which? _____
O surcical treatment
O Chemotherapy
O Radiation in the head and neck region

First diagnosed?_____

O **Do you currently have any other diseases or disabilities?**

_____

O **Do you smoke?**
How many cigarettes per day? _____

Do you take anticoagulants?
Permanently or in the last few days
O Aspirin® O ASS O Aggrenox®
O Marcumar® O Falithrom®
O Plavix® O Clopidogrel O Efient®
O Xarelto® O Eliquis® O Lixiana®
O Pradaxa®

Do you regularly take…?
O Blood pressure medication?
O Heart medication?
O Pain killers?
O Birth control pill?
O Psychopharmaka?
O Antidiabetic medication?
O other:_____

Name and dosage of medication:

_____

_____

_____

_____

With your signature you confirm the correctness and completeness of your details.

_____

Date Signature