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REGISTRATION FÜR ADULTS

Patient			
Last name, first name:		❑ male ❑ female	Date of birth DD/MM/YY):
Street address:		Postal Code, City:	
Telephone No. Home:	Mobile:	Telephone No.:	
Health Insurance Company:			Your weight (kg):
Dentist, name and address:		Last X-Ray(s) of skull, jaw or teeth (date):	
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*:
E-Mail:			

* 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):

- patient signature -

MEDICAL QUESTIONNAIRE

Dear patient,

We care about your wishes and your health. Therefore, we kindly ask you to fill in this questionnaire. All information is recorded electronically and is subject to medical confidentiality and data protection.

Do you come to see us due to…
O your dentist's referral?
O functional or CMD-issues?
O esthetic reasons
O recommendation by

_____

Have you ever had orthodontic treatment before?
O no
O yes
Where? _____

When? _____

O unfinished treatment

Did/do you.. have …..?
O speech disorders/speech therapy
When and which?

_____

O orthopedic problems / treatment?
When and which?

_____

CMD (Temporomandibular joint)
Do you suffer from
O Joint clicking?
O tooth grinding/pressing
O mouth opening limitation
O muscle pain in the facial region

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

Which?_____

Heart/Circulation
O Heart defect
O Myocarditis
O Endocarditis
O Artificial heart valves or blood vessels

other_____

Respiratory system
O Bronchial asthma
O Pneumonia
O Tuberculosis

other _____

Metabolic disorders
O Diabetes mellitus

other_____

Skeletal system
O Arthropathy, Rheuma
O Scoliosis
O Muscular diseases

other_____

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

other_____

Bleeding disorders
O Bleeding disorders (Haemophilia)
O Frequent nosebleed
O Bruises without injury

other_____

Immunity
O Organ transplant
O HIV positive

other_____

Did you ever have an accident affecting the teeth, head or neck region?

Which? _____

When? _____

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

_____

Do you regularly take any medication?

Name and dosage of medication:

_____

_____

_____

_____

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

_____

Date Signature