Zahnärzte an der Theaterstraße
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Registration form with anamnese

Dear Patient – a warm welcome to our Dental Office!

Please fill in the questionnaire for a risk-free treatment. Be so kind and answer all questions completely, regardless of whether you consider them important for your current problem or not. All your information given are subject to confidentiality. Thank you for your cooperation!

Patient _____
Last name: _____
First name: _____
Date of birth: _____
Address: _____
Country and
city of birth: _____
E-mail privat: _____

Main insured person (Parents, wife, husband, …)
Last name: _____
First name: _____
Date of birth: _____

Phone numbers
Privat: _____
Mobil: _____
Work: _____

Job: _____
Employer, place: _____

Who should receive the invoice?
Last name: _____
First name: _____
Address: _____

Name of insurance: _____
Privat O compulsory O voluntary O government O

How did you hear about us?
Recommendation from: _____
Internet: our website O
Jameda O
Google O
Others: _____

Are there any health risks?

Do you suffer from any allergy?	yes O	no O
If yes, which? _____		
Do you have a stomach or bowel disease?	yes O	no O
Do you have a cardiovascular disease?	yes O	no O
Do you have blood coagulation disorders?	yes O	no O
Do you have high blood pressure?	yes O	no O
… low blood pressure?	yes O	no O
Do you have diabetes?	yes O	no O
If yes, Type I O or Type II O		
Do you have osteoporosis?	yes O	no O
Do you take bisphosphonates?	yes O	no O

please turn around →

Do you have a thyroid disorder? yes O no O

Over function O or under function O

Do you suffer from any infectious disease? yes O no O

HIV O Hepatitis B O Hepatitis C O Tuberculesis O

Do you take any medicine? yes O no O

If yes, which one? _____

Do you have kidney disease? yes O no O

Do you suffer from migraine? yes O no O

Do you have a green star? yes O no O

Did / do you have cancer? yes O no O

If yes, which one? _____

Do you suffer from mental illness? If yes, which one: _____

Do you smoke? If yes how much per day? _____

Are you pregnant? yes O no O

If yes, which week? _____

Have you ever done a professional cleaning? yes O no O

If yes, when was the last one? _____

What is the reason for your visit?

A dental check-up yes O no O

Another reason _____

Do you have toothache? yes O no O

Do you have pain in the jaw- joint? yes O no O

Do you own an x-ray passport? yes O no O

Are there x-ray pictures of your oral-jaw area which are not older than 2 years? _____

Would you like to receive detailed information about implants? yes O no O

How important for you...	1 very important	2	3	4	5 unimportant
… are aestheticly beautyful teeth?	O	O	O	O	O
… is the straight position of your teeth?	O	O	O	O	O
… is the tooth colour?	O	O	O	O	O

I would like to be reminded of appointments for regular check-up and/ or Professional cleaning:
via letter O via e-mail O via phone O

With my signature, I confirm the accuracy of my information.

► The information on the collection of personal data can be seen at the reception in our dental office.

Aachen,_____ _____