Registration sheet with medical history

zahnmedizinisches kompetenzzentrum
WOLFSBURG MVZ

Porschestraße 74 • 38440 Wolfsburg • Phone: 0 53 61 | 18 81 0 • info@zmk-reiche.de

Name First name

Date of birth Place of birth

Address

Phone, private E-Mail

Profession Employer, place

Phone, business Health insurance company

Are you compulsorily insured? o yes o no Do you have a supplementary insurance? o yes o no

If you are not the health insurance holder yourself, who is the insured person?

Name First name Date of birth Place of birth

Who shall receive the invoice?

Name Address

Are you eligible for benefits as a public sector employee? o yes o no

Who is your family physician?

Name Address Phone

Why do you visit us for treatment?

Do you have a toothache?	o yes o no
Do you suffer from noises or pains in the jaw joint?	o yes o no
Tinnitus?	o yes o no
Do you grind your teeth?	o yes o no
Do you suffer from gum bleeding?	o yes o no
Do you suffer from receding gums?	o yes o no
Do you suffer from loosened teeth?	o yes o no

Do you wish for a ...

Routine check-up	o yes o no
Consultation	o yes o no
Second opinion	o yes o no
Pain treatment	o yes o no
Other	

How did you learn about our practice?

o Family/Acquaintances o Phone book/Yellow Pages o Internet o Advertisement

o Other

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Are you subject to any health risks? o yes o no

If yes, which?

_____

Do you have an allergy ID? o yes o no
If yes, to what are you allergic?

_____

Are you sensitive to certain medication? o yes o no
If yes, which?

_____

Do you suffer from clotting disorders? o yes o no
Do you suffer from disorders of your cardiovascular system or is your cardiovascular system currently being examined? o yes o no

- o Cardiac insufficiency
- o Cardiac valve infection
- o Irregular heart beat
- o Cardiac infarction
- o Pacemaker
- o Angina pectoris
- o Hypertensio
- o Hypotension

Are you HIV positive? o yes o no
Do you suffer from a disorder of your thyroid gland? o yes o no
Do you suffer from migraines? o yes o no

Do you suffer from …

- o Hepatitis B
- o Hepatitis C
- o Diabetes
- o Rheumatism
- o Tuberculosis
- o Disorders of the spine
- o Epilepsies
- o a disorder of the stomach, bowel or kidneys
- o Glaucoma
- o Prostate disorder
- o Asthma

Are you pregnant? o yes o no
If yes, in which week? _____
What medication are you currently taking?

_____

Do you take any anticoagulant drugs? o yes o no
If yes, which?

_____

Have you taken any bisphosphonates? o yes o no
If yes, which?

_____

Have you had an X-ray examination? o yes o no
Do you smoke? o yes o no

Notes on the organisation:

High quality is only possible without time pressure. Please cancel appointments that you cannot keep at least 24 hours in advance, so that we can give them to another patient.

Would you like to be reminded of your semi-annual preventive check-up/professional tooth cleaning?

o yes o no If yes: o by e-mail o by regular mail

Please fill in this questionnaire completely. It will be added to your personal files. As a matter of course, all information is subject to medical confidentiality.

I confirm to have entered all information above to the best of my knowledge and belief.

_____ _____

Date Signature