Registration form

Please complete and hand in the questionnaire before the treatment.

Surname, Christian name	date of birth:
complete address:	Tel. no.
	Occupation:
Health insurance:	
Complementary insurance	
If privately insured, invoice be send to:	
Dentist	

To insure an uncomplicated treatment please thoroughly answer the following:

	Yes	no
1. Have you got a pacemaker?		
2. Do you often suffer from gum bleeding?		
3. Have you (had) one of the following illnesses?		
a.) Asthma		
b.) allergies to or intolerance of pharmaceuticals- if so, which ones:		
c.) High blood pressure		
d.) Stroke, paralyses, if so, when:		
e.) Heart attack, if so, when:		
f.) Jaundice, liver diseases (hepatitis A, B, C, D) if so, which one?:		
g.) diabetes mellitus-		
if so, insulin-dependent?		
h.) Rheumatism		
i.) HIV positive / AIDS		
4. Do you suffer from hemic diseases or blood coagulation disorder?		
(Do you regulary take aspirin or other anticoagulants?)		
5. Are you suffering from other diseases/ illnesses- if so, which ones?		
6. Do you regulary take pharmaceuticals? If so, which ones?		
7. Have you got a heart passport?		
8. Have you got an X-ray passport ?		
9. When was your jaw area x-rayed last time?		

10. Women: Are you pregnant?

yes: no: not sure: which month:

Date: signature patient or guardian: