DR. HÖLLEIN
Praxis für
Zahnheilkunde

REGISTRATION FORM AND MEDICAL HISTORY

Please answer the following questions about your state of health as accurately as possible. This information is subject to medical privacy and data protection laws and will be handled with strict confidentiality!

Last name | First name | Date of birth / Place of birth

Street | Postal code | Town

Home phone | Mobile phone | Fax | E-mail

Occupation | Your Employer | Phone number at work

Insurance company

Who is the insured, if not yourself?

Last name | First name | Date of birth / Place of birth

Street | Postal code | Town

Do you receive any benefits/allowances from public authorities or agencies? ☐ yes ☐ no

Who has recommended us? How did you hear about us?

☐ Yes, I hereby to receive information. The consent can be revoked at any time.

Why are you seeking care?

Do you feel pain? ☐ yes ☐ no
Do your gums bleed? ☐ yes ☐ no
Have your gums receded? ☐ yes ☐ no
Do you feel pain at the temporomandibular joint? ☐ yes ☐ no
Do you like the look of your teeth? ☐ yes ☐ no

Do you have any primary diseases or health risks?

Are you receiving medical care at the moment? ☐ yes ☐ no
Are you taking any medication at the moment? ☐ yes ☐ no
If so, which?

Are you pregnant? ☐ yes ☐ no
Who is your physician/family doctor?

Do you have a list of medication medical record card? ☐ yes ☐ no
Do you have a cardio-vascular disease? ☐ yes ☐ no
If so, which?

Are you allergic to any medication? ☐ yes ☐ no
If so, which?

Do you suffer from diabetes? ☐ yes ☐ no
Do you suffer from gastro-intestinal disease? ☐ yes ☐ no
Do you suffer from migraine? ☐ yes ☐ no
Do you suffer from glaucoma? ☐ yes ☐ no
Do you suffer from prostate disease? ☐ yes ☐ no
Do you suffer from rheumatism? ☐ yes ☐ no
Have you ever undergone tumor treatment? ☐ yes ☐ no
Were you ever on bisphosphonates? ☐ yes ☐ no
Have you ever had any infectious disease? ☐ yes ☐ no
☐ Hepatitis A/B ☐ HIV/AIDS ☐ Tuberculosis
Have you ever received an artificial heart vaive/ articulation (hip, knee, shoulder)/pacemaker? ☐ yes ☐ no
Do you suffer from asthma? ☐ yes ☐ no
Do you take anticoagulant drugs? ☐ yes ☐ no
Do you smoke? ☐ yes, ca. ☐ cigarettes/day ☐ no

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Have you ever received dental treatment for any severe conditions?

Have you ever had any side effects on injections in the past? ☐ yes ☐ no
If so, which?

Do you have a fixed denture? ☐ yes ☐ no
If so, since when?

Do you have a removable denture? ☐ yes ☐ no
If so, since when?

Have you ever undergone periodontal treatment in the past? ☐ yes ☐ no
When approximately?

Have you ever been in orthodontic-care? ☐ yes ☐ no

Have you ever had a night guard in the past? ☐ yes ☐ no

Have you had your teeth radiographed in the last two years? ☐ yes ☐ no

Would you like a special consultation about:

Amalgan removal? ☐ yes ☐ no
Aesthetic dentistry? ☐ yes ☐ no
Tooth colored ceramic fillings? ☐ yes ☐ no
Bleaching? ☐ yes ☐ no

Periodontal care? ☐ yes ☐ no
Temporomandibular joint-care? ☐ yes ☐ no
Implants? ☐ yes ☐ no
Other:

Please, answer all these questions. Secrecy on our part is guaranteed. If any answer has changed, please let us know immediately.

If you cannot keep your appointment please let us know at least 24 hours beforehand.
In case of no appearance you will receive an innvoice for the treatment time.

Place / Date

Signature

Print form

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