DR. FELIX BERGSCHNEIDER
FACHPRAXIS FÜR KIEFERORTHOPÄDIE

REGISTRATION AND MEDICAL HISTORY FORM

Dear Patient,

welcome at our orthodontic practice. Please write your contact details below, answer the health questions and sign the form. All informations will be kept strictly confidential. (§203 StGB)

PATIENT

last name, first name _____ date of birth _____

address _____ postal code, city _____

home phone no. _____ mobile phone no. _____ profession _____

e-mail address _____

insurance _____

☐ private insurance ☐ legally insured ☐ additional insurance

PRIMARY POLICY-HOLDER'S NAME

last name, first name _____ date of birth _____

address _____ postel code, city _____

home phone no. _____ mobile phone no. _____ profession _____

email-address _____

LEGAL GUARDIAN

last name, first name _____ phone no. _____

PATIENT'S DENTIST

last name, first name _____ city _____

PLEASE TURN THE PAGE

DO YOU HAVE OTHER FAMILY MEMBERS OR FRIENDS TREATED HERE?

☐ no ☐ yes/name _____

DATE OF THE MOST RECENT TAKEN X-RAY (WITHIN 12 MONTHS)

☐ no ☐ yes/practice _____

TOOTH GRINDING OR JAW CLENCHING?

☐ no ☐ yes

BEEING TREATED BY ANOTHER ORTHODONTIST BEFORE?

☐ no ☐ yes/practice _____

ANY ALLERGIES OR REACTIONS?

☐ no ☐ yes/which _____

INJURIES, ACCIDENTS OR OPERATIONS IN THE MOUTH REGION?

☐ no ☐ yes/which _____

DO YOU SUFFER FROM ANY INFECTION DESEASE? (E.G. HIV, TBC, HEPATITIS, ETC.)

☐ no ☐ yes/which _____

FEMALE PATIENTS: IS THERE A PREGNANCY?

☐ no ☐ yes ☐ unknown

DO YOU SMOKE TOBACCO?

☐ no ☐ yes

WHAT IST YOUR PRIMARY CONCERN?

_____

_____

_____ _____

date signature (patient/primary policy-holder/guardian)

I understand, it is my responsibility to inform the practice if I, or my minor child, ever have a change in health.