

|                                |                  |        |
|--------------------------------|------------------|--------|
| Krankenkasse bzw. Kostenträger |                  |        |
| Name, Vorname des Versicherten | geb.am           |        |
| Kassen-Nr.                     | Versicherten-Nr. | Status |
| Betriebsstätten-Nr.            | Arzt-Nr.         | Datum  |

Versicherte(r)

|                                    |         |
|------------------------------------|---------|
| Behandlungseinrichtung             | Beh.-ID |
| Dr. Felix Bergschneider            |         |
| Fachzahnarzt für Kieferorthopädie  |         |
| Louis-Appia-Passage 9              |         |
| 60314 Frankfurt am Main            |         |
| Behandelnde(r) Ärztin/Arzt:        | Arzt-ID |
| Dr. med. dent. Felix Bergschneider | 1       |

Dokumentation zum Patientengespräch:  
Anamnese ENG

REGISTRATION AND MEDICAL HISTORY FORM

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

Y = Yes | N = No

PATIENT

Title:  
\_\_\_\_\_

last name:  
\_\_\_\_\_

first name:  
\_\_\_\_\_

date of birth:  
\_\_\_\_\_

address:  
\_\_\_\_\_

postal code, city:  
\_\_\_\_\_

profession:  
\_\_\_\_\_

CONTACT DETAILS

home phone no.:  
\_\_\_\_\_

mobile phone no.:  
\_\_\_\_\_

e-mail address:  
\_\_\_\_\_

INSURANCE

insurance  
\_\_\_\_\_

☐ legally insured

☐ private insurance

☐ additional insurance

## Anamnese ENG

### PRIMARY POLICY-HOLDER'S NAME

☐ identical

last name:

first name:

date of birth:

address:

postal code, city:

home phone no.:

mobile phone no.:

email-address:

profession:

### LEGAL GUARDIAN

last name, first name :

phone no.:

### PATIENT'S DENTIST

last name, first name:

city:

**DO YOU HAVE OTHER FAMILY  
MEMBERS OR FRIENDS  
TREATED HERE?**

Y ☐ N ☐

**HAVE YOU HAD AN X-RAY  
IN THE LAST 12 MONTHS?**

Y ☐ N ☐

**TOOTH GRINDING OR JAW  
CLENCHING?**

Y ☐ N ☐

**BEING TREATED BY ANOTHER  
ORTHODONTIST BEFORE?**

Y ☐ N ☐

**ANY ALLERGIES OR REACTIONS?**

Y ☐ N ☐

**INJURIES, ACCIDENTS OR  
OPERATIONS IN THE MOUTH  
REGION?**

Y ☐ N ☐

**DO YOU SUFFER FROM ANY  
INFECTIOUS DISEASE?  
(E.G. HIV, TBC, HEPATITIS, ETC.)?**

Y ☐ N ☐

### GENERAL

Gender:

☐ F ☐ M ☐ D

**FEMALE PATIENTS:  
IS THERE A PREGNANCY?**

☐ No ☐ Yes ☐ Unknown

**DO YOU SMOKE TOBACCO?**

Y ☐ N ☐

**WHAT IS YOUR PRIMARY CONCERN?**

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



Signature of the patient/patient's guardian

Place/date:

### Consent and Release from the Duty of Confidentiality

#### Billing and Collection of Medical Fees

##### Patient

Surname:

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First name:

---

Date of birth:

---

I consent to the processing by the doctor treating me,

**Dr. Felix Bergschneider,**

of the personal data required for billing and collecting my medical fees and, where necessary, to the disclosure of such data to appointed billing service providers, debt collection agencies or lawyers.

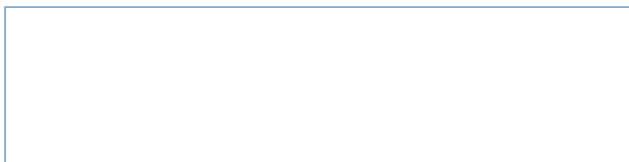
This includes, in particular, my identification and contact details, as well as information about invoices, the amount and due date of claims, payments and reminders. Medical information will only be disclosed to the extent necessary for billing or the specific enforcement of a fee claim.

#### Release from the duty of confidentiality:

To the extent that the disclosure of information described above is subject to the doctor's duty of confidentiality, I release the above-named doctor from that duty solely in relation to the appointed billing service providers, debt collection agencies and lawyers.

This release applies exclusively to the billing and, where necessary, the out-of-court and court collection of specific medical fee claims. It does not cover the blanket disclosure of my patient records, medical findings or medical information that is not necessary for these purposes.

I have been informed that I may withdraw this consent and release from the duty of confidentiality at any time with effect for the future. Withdrawal does not affect the lawfulness of any processing carried out before the withdrawal.



Signature of the patient

Place/date: