ZAHNARZT
DOKTOR
REINEKE

registration form
sheet of anamnesis

Dear patient,

we need this information about you:

Patient: .....
name surrname date of birth

Adress: .....
postcode city street

Phone: .....
Privat Mobile work

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

Heart/cardiovascular diseases:

High blood pressure	❑ yes	❑ no
Low blood pressure	❑ yes	❑ no
Heart valve disease	❑ yes	❑ no
Heart valve replacement	❑ yes	❑ no
Pacemaker	❑ yes	❑ no
Endocarditis	❑ yes	❑ no

other diseases:

Severe neutropenia	❑ yes	❑ no
Cystic fibrosis	❑ yes	❑ no
Organ transplant	❑ yes	❑ no
Stem cell transplant	❑ yes	❑ no
Epilepsy	❑ yes	❑ no
Asthma/lung diseases	❑ yes	❑ no
Blood clotting disorders	❑ yes	❑ no
Diabetes	❑ yes	❑ no
Drug dependency	❑ yes	❑ no
Nerve disease	❑ yes	❑ no
Kidney diseases	❑ yes	❑ no
Fainting spells	❑ yes	❑ no
Osteoporosis	❑ yes	❑ no
Smoker	❑ yes	❑ no
Rheumatism/arthritis	❑ yes	❑ no
Thyroid disease	❑ yes	❑ no

Other diseases: .....

Infectious diseases: .....

Zahnarztpraxis
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Allergies or intolerances:

HIV/AIDS	❑ yes	❑ no
Liver disease/Hepatitis	❑ yes	❑ no
Tuberculosis	❑ yes	❑ no
Local anesthesia/injections	❑ yes	❑ no
Antibiotics	❑ yes	❑ no
Pain medication	❑ yes	❑ no
Metals (if yes, witch one)	❑ yes	❑ no
Other infectious diseases	❑ yes	❑ no

Any other diseases:

.....

Are you pregnant? ❑ no
❑ yes, ... Month

Have you had dental x-rays (If yes, when?) ..... ❑ yes ❑ no

Which medication do you take regularly or are currently taking:

.....

Do you take bisphosphonates since ..... ❑ yes ❑ no

Are you receiving chemotherapy medication since ..... ❑ yes ❑ no

Are you receiving radiation therapy for cancer since ..... ❑ yes ❑ no

Are you taking high-dosage steroids / immunosuppressants since ..... ❑ yes ❑ no

Have you had major surgery carried out in hospital Date ..... ❑ yes ❑ no

I hereby authorise the electronic storage, processing and use of my data for input in the Recall System.

I agree to immediately report any and all changes arising during the entire treatment period. I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

.....

Location / Date Signature Patient

Thank you very much!

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