



Dear patients,

you are warmly welcome to the dental office Dr. Lange. Thank you for your trust. Please complete this form correctly and inform us about any changes to state of health, adress and your insurance, from know on.

Patient

Mr./Mrs./child

surname name birthdate

Adress

street / number postcode / city

call number – private call number – business mobil

email

Insured person

(member)

surname name birthdate

Insurance Company

state health insurance private insurance other:

additional insurance-dental

Profession

(member)

employer

Did you ever had or do you have one of the following diseases? (please mark the appropriate box)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Hepatitis A/B/C
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Suffering from epilepsy	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> HIV
<input type="checkbox"/> Thyroid diseases	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Coagulation disorder	<input type="checkbox"/> Tuberculosis

Blood pressure low normal high

Other diseases

Uncompatibilities with drugs or materials

Do you take regular drugs? yes no which drugs?

Do you smoke? yes no

Are you pregnant? yes no uncertain week of pregnancy?

How did you become aware of us?

With my signature i confirm that my details are complete and correct. I agree with the recording of my personal dates.

date

signature