PATIENT REGISTRATION & MEDICAL HISTORY FORM

Dear Patient!

Welcome to BonnSmile – we are delighted to have you with us! Providing you with personal care tailored to your health needs and individual wishes is especially important to us. To do so, we kindly ask you to provide us with some personal and health-related information. Of course, all information you provide is subject to medical confidentiality.

INFORMATION – MISSED APPOINTMENTS

We always aim to keep waiting times to a minimum. For this reason, we reserve treatment time specifically for you. If you are unable to attend your appointment, this results in unused treatment time in our practice. We therefore kindly ask you to cancel scheduled appointments at least 24 hours in advance, and appointments scheduled for one hour or longer at least 48 hours in advance. If we are unable to reallocate the appointment, we are entitled to charge for missed appointments based on the time reserved and the treatment planned, in accordance with Section 615 of the German Civil Code (BGB).

PATIENT DETAILS

Name	First Name	Date of Birth
Street/House Number	Postal Code	City
Phone (Landline / Mobile)	Email Address	Occupation
General Practitioner	Statutory Health Insurance: ☐	Supplementary Dental Insurance: ☐ Yes
	Private Health Insurance: ☐	☐ No
Krankenkasse		

If you are not the policyholder yourself, who is the insured person?

Name	First Name	Date of Birth
Street/House Number	Postal Code	City

HOW DID YOU HEAR ABOUT OUR PRACTICE?

HEALTH INFORMATION

Please answer the following questions to help us provide you with safe and effective treatment. All information you provide is subject to medical confidentiality. Your overall health is at the heart of our approach, as oral health is closely connected to your general well-being. Your answers help us tailor your treatment to your individual needs and identify any relevant connections that may be important for your health.

- ☐ Asthma / Lung Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Paralysis
- ☐ Blood Clotting Disorders
- ☐ Epilepsy
- ☐ Depression / Psychosis
- ☐ Neurological Disorders

- Jaundice
- Liver Disease
- Immune System Disorders (e.g. HIV)
- Diabetes Mellitus
- Rheumatic Disease
- Blood Disorders
- Hypotension (Low Blood Pressure)
- Hypertension (High Blood Pressure)
- Drug Addiction
- Osteoporosis
- Impaired Wound Healing
- Tumor Diseases / Cancer
- Previous Periodontal Treatment
- Pacemaker
- Hepatitis
- Allergies:

Other Medical Conditions / Additional Information:

Do you take any medications regularly?	No	Yes: Which ones?	
Any medication intolerances?	No	Yes: Which ones?	
Do you smoke?	No	Yes: How much?	Cigarettes per day
Are you pregnant or breastfeeding?	No	Yes	Week of Pregnancy

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION I HAVE PROVIDED IS COMPLETE AND ACCURATE AND THAT I HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ON THIS PATIENT REGISTRATION AND MEDICAL HISTORY FORM.

X

Place, Date **Signature** of Patient (or Legal Representative, if applicable*)

OUR SERVICES FOR YOU
Please tick if desired.

To help keep your smile healthy for years to come, we would be happy to support you with our friendly reminder and preventive care service.

- **Appointment Reminder**
Iwould like to receive reminders for appointments already scheduled at BonnSmile.

- **Preventive Care Reminder System**
I would like to be included in BonnSmile's preventive care reminder system and receive regular reminders for my six-monthly dental check-ups as well as recommended appointments for professional dental cleaning and preventive care.

You may contact me via (multiple selections possible):

Mail ☐ EMail ☐ Phone ☐

COMMUNICATION WITH OUR PRACTICE

I agree that BonnSmile may contact me regarding organisational matters and matters related to my treatment using the contact details I have provided, by mail, email or telephone.

I understand that with standard unencrypted email communication, complete protection against access by unauthorised third parties cannot be technically guaranteed.

Consent is voluntary and may be withdrawn at any time with effect for the future.

X

Place, Date **Signature** of Patient (or Legal Representative, if applicable*)

*For minors or where otherwise required: signature of the legal representative.