Registration file

Thank you for choosing our dental surgery!

We exclusively schedule your appointments to prevent waiting times. If you are unavailable for a booked appointment please ensure to cancel at least 24 hours in advance.

We will store your data digitally in strict adherance to medical confidentiality and data privacy. Please confirm the information given to you as well as the accuracy of you data with your signature on the next page. Thank you very much!

Dear patient,

A visit to the dentist is a matter of trust. Thank you for trusting us with your dental health.

To enable us to provide you with the best possible treatment, could you kindly complete both pages of this form with your information.
Should you have any issues with your health, please ensure to tick the corresponding boxes on page 2.
This helps preventing risks during your treatment.

Let us know if you have any dental concerns, and what aspects you care about the most.

Medical confidentiality applies to all data provided. Please let us know if any of your details change.
Thank you very much!

Your dentist

Dr. Torsten Krell & accociates

Patient

Name: _____

First name: _____

Street: _____

Postcode/Town: _____

Date of birth: _____

Profession: _____

Employer: _____

Health insurance: _____

General practitioner: _____

Phone: _____

Mobile: _____

E-Mail: _____

Work phone: _____

Insurance holder (parent, spouse)

Name: _____

First name: _____

Street: _____

Postcode/Town: _____

Date of bith: _____

Profession: _____

Employer: _____

Health insurance scheme

- ☐ Statutory insurance
- ☐ Private health insurance (fully insured)
- ☐ Private health insurance (standart rate)
- ☐ Benefit
- ☐ Additional insurance, if so, which _____

How did you hear about this practice?

☐ Recommended by:

_____

Internet
- ☐ Google
- ☐ Jameda
- ☐ other:

_____

Purpose of my visit

- ☐ check up
- ☐ toothache
- ☐ loose teeth
- ☐ gum bleeding
- ☐ missing teeth
- ☐ problems with artificial dentition
- ☐ new artificial dentition
- ☐ aesthetic reasons
- ☐ TMJ problems
- ☐ teeth grinding
- ☐ other: _____

I would like to be informed about:

- ☐ prophylaxis
- ☐ periodontal treatment
- ☐ removal of amalgam fillings
- ☐ teeth grinding/ CMD
- ☐ alloy-free teeth
- ☐ artificial dentition
- ☐ dental implants
- ☐ fixed dental prothesis
- ☐ Improvement of denture retention
- ☐ ceramic inlays
- ☐ all-ceramic crowns/bridge
- ☐ porcelain veneers
- ☐ beautification of my teeth
- ☐ tooth whitening
- ☐ other:

_____

Please turn to page 2

Dr. med. dent.
Torsten Krell
& Kollegen

Kaiserstr. 3
60311 Frankfurt/Main
Tel. 069 - 59 67 57 59

www.zahnarzt-frankfurt-zentrum.de

Your state of health

Ilnesses, medication and allergies can affect dental treatments. Only if we know details on your state of health, we can give you an appropriate treatment. If you have an allergy registration, please bring it to your appointment. If you are under medication currently, please give us details on that as well.
Thank you very much!

Do you smoke?
☐ No ☐ Yes: How many? _____

Ladies only: Are you pregnant?
☐ No ☐ Yes; How many months? _____

Do you have any allergies?
☐ No ☐ Yes, to _____

Do you take cancer or ostheoporosis medication?
☐ No ☐ Yes, i take _____

Do you take anticoagulative medication?
☐ No ☐ Yes, I take _____

Do you take any medication regularly?
☐ No ☐ Yes, I take _____

Symptoms/Ilnesses

☐ I am in pain
☐ I grind my teeth
☐ My jaw is clicking
☐ I feel pain while opening my mouth
☐ I suffer from gum bleeding?
☐ I suffer from headaches in the
☐ morning ☐ afternoon ☐ evening
☐ Orthodontic treatment was performed
☐ My last dental treatment was _____
☐ I have regular professional dental cleanings
☐ Heart/ circulation diseases
☐ Artificial heart valve
☐ Endokarditis
☐ Heart surgery was performed/ pace-maker
☐ Heartattack
☐ Stroke
☐ Subsequent hemorrhaging
☐ Immunodefficiancy (e.g. HIV)
☐ MSRA– infection
☐ Creutzfeld-Jakob disease (vCJK)
☐ Problems with wound healing
☐ Diabetes
☐ Bone marrow diseases
☐ Radiation therapy of the jaw
☐ Osteoporosis
☐ Tumors/ Cancer
☐ Periodontal treatment was performed
☐ Drug addiction
☐ Asthma/ lung diseases
☐ Depression/neurological disease/psychosis
☐ Liver diseases
☐ Kidney diseases
☐ Epilepsy
☐ Stomache diseases
☐ Hepatitis. Which one?_____
☐ Other: _____

My therapy requests

☐ I want the best for my teeth. Please inform me about the ideal treatment options, even if they are not covered by my insurance.
☐ I would like local anaesthetics for all treatments
☐ I would like local anaesthetics only if a treatment is painful
☐ I would like to be informed about all details of the treatment
☐ I don‘t like to be informed about details of the treatment
☐ I am afraid of dental treatment
☐ I am interested in laughing gas sedation
☐ I would like to be recalled for the professional cleaning/check up
☐ Other:

Tip:
Statutory insuraced patentients, please bring your insurance card and ‚Bonusheft‘.

I confirm the completness and accuracy of the given information.

✘ _____ _____
(date) (signature)

Appointments

If this file has been send to you or if you downloaded it from our website, we kindly ask you to send or e-mail it back to us in advance of your appointment.

We exclusively schedule your appointments to prevent waiting times. If you are unable to visit, please cancel your appointment at least 24 hrs in advance . Otherwise the scheduled treatment will be invoiced according to §615 BGB. Thank you for understanding.

I took note of the information above. I accept to pay an appropriate compensation in case of canceling at short notice.

✘ _____ _____
(date) (signature)

Please scan and save our address and phone number with you smartphone to have it at hand any time you need it.
Requires Scan-Apps are available at the App-store/ Play-store

Scan and save our address

Dr. med. dent.
Torsten Krell
& Kollegen

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