Registration

Please fill out before your appointment and give it back at the front desk. Thank you!

Patient **date of birth**

Name Surname

If Minor: legal guardian _____

Adress: _____

Phone : _____ **E-Mail:** _____

Name of your insurance copany: _____

Are you healthy or do you have problems with:

Allergies ☐ yes ☐ no

If yes, which allergies do you have? _____

Asthma ☐ yes ☐ no

Blood Clot disorder ☐ yes ☐ no

High bloodpressure ☐ yes ☐ no

Low bloodpressure ☐ yes ☐ no

Heart ☐ yes ☐ no

do you have a **pacemaker ?** ☐ yes ☐ no

Liver ☐ yes ☐ no

did you had a **stroke?** ☐ yes ☐ no

Kidneys ☐ yes ☐ no

Diabetes ☐ yes ☐ no

Do you smoke? If yes how many per day?

other information: _____

Family doctor:

Do you take any medicine regulary? Please write down which medicine you take and if you have one, please give us a list To make a copy.

_____

When was the last time you were XRay`ed? _____

Please let us know of any changes in your health or address.

Dear patient!

You come to a practice that is managed according to the ordering system. In this way we can avoid long waiting times because we make a fixed appointment with our patients. We would like to ask you to keep your agreed appointment.
If you are unable to attend, we ask that you cancel in good time, in good time means: 2 working days in advance.

Would you like a reminder of the next check-up or the next prophylaxis appointment? ☐ yes

With my signature, I confirm the correctness and completeness of my information and agree to the processing of personal data concerning me. I have been advised that the privacy policy is posted in the waiting room.

Date _____ signature _____

Thank you for your cooperation!