DR. SONJA MÜNCH
ZAHNÄRZTINNEN
DR. ROSWITHA GRAF

REGISTRATION

Patient: Last name / surename | First name / forename | Date of birth

Address | Phone at home

Insurant: Last name / surename | First name / forename | Date of birth

Address | Phone at home

E-Mail | **Mobile**

Occupation | Place of work / employer | Phone at work

Address

Insurance: Statutory | Private

Medical history

Are you on any regular medication?	☐ Jes ☐ No
Do you have any allergies?	☐ Jes ☐ No
Do you suffer from heart disease?	☐ Jes ☐ No
Do you have any circulatory problems?	☐ Jes ☐ No
Do you have any metabolie disorders?	☐ Jes ☐ No
Do you have any blood disease?	☐ Jes ☐ No
Do you have any infectious disease?	☐ Jes ☐ No
Do you smoke?	☐ Jes ☐ No
Are you pregnant?	☐ Jes ☐ No

Please note:
You have to give at least 24 hours notice if you wish to cancel your appointment.
Otherwise we will have to invoice you for the lost time. We ask for your understanding.

Your personal data is carefully kept secret to the public. They are protected by doctor-patient-confidentiality through German federallaw (§203 StGB) and the strict rules of privacy. We kindly ask you to thoroughly and truthfully fill out this form.
It is our declared endeavour, to make your stay in this dental office as pleasant as possible. In case something seems unsatisfactory to you, please do not hesitate to inform uso We can only improve things with your feedback.
Thank you.

Date, Signature | Thank you very much for your co-operation. Please inform us of any changes.

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