REGISTRATION AND CLINICAL HISTORY FORM

DEAR PATIENT,
WELCOME TO OUR DENTAL OFFICE!

Our team at B₂V DR BRANDT + KOLLEGEN is committed to making sure that your visits will be as comfortable as possible. In this form, you will be asked to provide basic data about your person and health. We need this information to optimize treatment, eliminate risks, and provide dental care at the highest level. Your willingness to share these details will enable a customized treatment strategy aimed at meeting your individual health requirements and your personal expectations. If you have any questions, do not hesitate to ask. The details you are going share are subject to medical privacy under German law (§ 203 StGB) and will be used confidentially.

CONTACT DETAILS

Surname | First Name

Degree or Title

Sex | Gender

Street Address

Birth Date | Birth Place

Postal Code | Town or City

Phone (Home)

Phone (Mobile) *Optional. Share if you want us to use this channel for communications about your dental and general health.

E-mail *Optional. Share if you want us to use this channel for communications about your dental and general health.

Insurance Provider

General Practitioner (Name | Place | Phone)
*Optional. If we consider a transfer of documents from your practitioner to be useful, we shall approach you for consent.

INSURANCE

Do you have general European/German health insurance ? ☐ Yes ☐ No

Do you have private insurance covering dental treatment? ☐ Yes ☐ No

Do you have additional/supplemental insurance covering dental treatment? ☐ Yes ☐ No

Unless you are insured yourself, who is insured?

Surname | First Name

Street Address

Date of Birth

Postal Code | Town or City

Phone (Home)

How did you find out about us?
*Optional. For internal office statistics.

☐ Website ☐ Jameda ☐ Newspaper advertisement

☐ Recommended by

☐ Other

PLEASE TURN PAGE

ABOUT YOUR DENTAL HEALTH

Please check appropriate boxes.

Have you noticed problems with your gums, bleeding during brushing, or shrinking of gums? ☐

Do your jaw joints cause discomfort, or do you often experience headaches, neck pain, or migraine? ☐

Do you suffer from bruxism (do you clench or grind your teeth)? ☐

Do you suffer from bad breath or bad taste in your mouth? ☐

Are you afraid of dental treatment? ☐

Have you undergone orthodontic treatment (for example, did you ever wear braces)? ☐

Have you had your teeth professionally cleaned on a regular basis? ☐
*This information is optional, although useful for treatment.

Are you satisfied with the position, color, and shape of your teeth? ☐
*This information is optional, although useful for treatment

Are there any specific points you would like to share with us? ☐
*This information is optional, although useful for treatment

If so, what are they? _____

I understand that my traffic safety skills may temporarily be compromised by any local anesthesia and medications that may be administered to me before and during treatment.

By signing this form, I expressly consent to the storage of my personal data and confirm that the details I have shared on both sides of this sheet are complete and correct. If any of these details change, I undertake to communicate these changes in time.

Note on appointments: To avoid long waiting periods, we run our office on the basis of appointments. The time for each of your scheduled visits will be appropriated for you exclusively, considering that quality work takes time. Please understand that we may be charging a private fee for any missed appointments not canceled 24 hours in advance.

_____ _____

Place | Date Signature

PRIVACY OF PERSONAL DATA AND VOLUNTARY SHARING OF INFORMATION

The consent I have given constitutes the legal basis for processing any of the information I have voluntarily shared. I understand that this consent can be withdrawn by a written statement, e-mail being acceptable, to your office (responsible for my data) at any time (Art. 7 Par. 3 GDPR).

I also understand that this right to withdraw my consent will not affect the lawfulness of processing based on consent before its withdrawal (second sentence of Art. 7 Par. 3 GDPR).

_____ _____

Place | Date Signature

PLEASE NOTE PAGE 3

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61118 Bad Vilbel, Germany

T +49 6101 85709
F +49 6101 87692

b2v-zahnmedizin.de
praxis@b2v-zahnmedizin.de

ABOUT YOUR GENERAL HEALTH

Please check appropriate boxes.

Do you have any of these symptoms or diseases of organ systems?

- ☐ Epilepsy
- ☐ Liver disease
- ☐ Lung disease (e.g., asthma)
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Gastrointestinal (stomach/bowels)
- ☐ Joints (rheumatic)
- ☐ Osteoporosis
- ☐ Increased intraocular pressure
- ☐ Tumor disease
- ☐ Immunosuppression
- ☐ Psychosomatic disease
- ☐ Prolonged bleeding
- ☐ Allergies (show us your allergy card)

If so, which? _____

☐ Diabetes

If so, which type? _____

☐ Heart disease (for example: infarction | angina | valvular | pacemaker | arrhythmia)

If so, which? _____

☐ Other cardiovascular disorders (for example: hypertension | circulation problems | dizziness)

If so, which? _____

☐ Infectious disease (e.g., hepatitis | HIV/AIDS | tuberculosis | hospital-acquired pathogens | Creutzfeldt-Jakob or variant)

If so, which? _____

☐ Other _____

SPECIFIC QUESTIONS ABOUT YOUR HEALTH

Please check appropriate boxes.

What medications do you take?

_____

Do you take bisphosphonates? ☐

Have you ever responded to medications or anesthetics by intolerance? ☐

If so, please explain: _____

Are you pregnant? ☐ Week | Month _____

Do you smoke? ☐ Quantity per day _____

Do you snore? ☐

When were you last X-rayed? _____

By signing this form, I expressly consent to the storage of my personal data and confirm that the details I have shared on this sheet are complete and correct. If any of these details change, I undertake to communicate these changes in time.

_____ _____

Place | Date Signature

Thank you very much for your time!
Your team at B_2V DR BRANDT + KOLLEGEN

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